MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Embassy Suites
1250 22nd Street, N.W.
Washington, D.C.
Monday, December 14, 1998

The meeting in the above-entitled matter convened, pursuant to notice at 10:11 a.m.

COMMISSIONERS PRESENT:

GAIL R. WILENSKY, Ph.D., Chair

JOSEPH P. NEWHOUSE, Ph.D., Vice Chair

P. WILLIAM CURRERI, M.D.

ANNE JACKSON

SPENCER JOHNSON

PETER KEMPER, Ph.D.

JUDITH LAVE, Ph.D.

DONALD THEODORE LEWERS, M.D.

HUGH W. LONG, Ph.D.

WILLIAM A. MacBAIN

WOODROW A. MYERS, M.D.

JANET G. NEWPORT

GERALD M. SHEA

C O N T E N T S

P R O C E E D I N G S [10:11 a.m.]

DR. WILENSKY: We're ready to start the morning session, the first one is on Medicare+Choice. Sarah and Scott?

MS. THOMAS: Good morning. At Tab B in your mailing materials you'll find a draft of the Medicare+Choice chapter of the March report, which has been a team effort bringing together the expertise of staff who have worked on risk adjustment, consumer information and quality as well as those working on the base payment amounts.

You'll notice that the chapter still has some holes but we intend to fill them by the January meeting.

The recommendations and story line are taken mostly from your discussions at the October meeting with a little bit of additional information from the September meeting. What we'd like you to do this morning is to talk about the two potential recommendations we have for the chapter and about the story line and issues that we've discussed in the chapter.

If you have written editorial comments, I'd be happy to take them or you can give them to Murray or Stu over the next days. We'll be going through a process of internal review and edit though so you will probably expect to see a fair amount of changes to the wording just to tighten it up and make it clearer.

I'm going to spend just a little time going over the organization of the chapter to get you started and then after I finish Scott's going to go over some recent information on the plan, trends in the plan, participation and the pull outs.

There are four sections of the chapter. The first is introduction and recommendations. The second review is the major policy changes in Medicare+Choice. The third section describes the plan's reactions to the changes and to other events. The final section gets into what the goals for the program are and how to think about measuring whether the program is meeting those goals.

Now to get to specifics. Again, the first section is the introduction and recommendations for Medicare+Choice. The background information in this part takes the reader through the events of this year from announcement of the payment rates to publication of the regulation and introduces the issues of participation; that is that very few new entrants of the types anticipated by Congress joined and existing contractors dropped out.

We put the two recommendations up front here. One that urges HCFA to continue to work with plans, the other that basically says it's too soon to tell how changes in participation suggest needed changes to the payment rates or method.

The next section takes the reader through five key issues that we think have played a role in the decisions of plans to participate. We certainly could include more but we kept it to five because I guess we think these are the most important and just to keep it a manageable chapter length.

Two of these are strictly payment with the payment system affecting both 1998 and '99 participation systems and risk adjustment affecting decisions to participate in 2000. Just a reminder on risk adjustment, you made recommendations on risk adjustment in both last year's March report and in your fall comment letter to HCFA. The staff is hoping to get the encounter data from plans to analyze the effect of the new system in January.

You'll have the opportunity to react to the secretary's report on the interim system which is due
March 1. You may remember that the Commission has 60 days to comment which will put you at the end of April.

Going back to the chapter, the section on premiums, benefits and service areas brings into the story the issue of the earlier ACR submission. It also describes policy changes that may have contributed to the shrinking service areas.

The section on beneficiary information describes the new information reporting and disclosure requirements that plans have told us that they find burdensome. It also describes the new cost of plans of the user fees to support the education campaign.

The last section on quality points out both how the standards reflect Medicare shift to the role of a health care purchaser demanding accountability and the ways in which the new requirements might concern either participating or potential new organizations.

The third section describes what we know so far about plan reactions to the Medicare+Choice program. We'll provide what we know about pull outs and we'll get into more detail here as we finalize our analysis of the database that Scott's putting together. But the basic scope of the problem, that is the number of contracts, counties and people affected in October is pretty close to what we know now.

We also are beginning to get a feel for benefits changes which appear to be fairly minor. There's also a brief discussion of other strategies plans might have taken in response to the Medicare+Choice changes and of the constraints they likely face for pursuing them.

The final section is the sketchiest at this time. The main idea is to take Gail's suggestion at the October meeting and use the legislative language and policies in the BBA to articulate important goals Congress had for Medicare+Choice. We'll try to identify the main priorities, and your thoughts on these are most welcome, and point out where there are tensions between achieving multiple goals. Then the section will get into the issues around measuring the success of the program against its goals. This discussion we view as setting the stage for the Commission's work in the coming year on Medicare+Choice.

We will wind up the fourth section with some specific activities that we are planning, evaluating the relationships between a host of factors, plan participation and enrollment and measuring the impact of the interim risk adjustment system on plans. So with that overview, Scott's going to walk you through the latest information about plan pull outs.

DR. HARRISON: Thanks. On Table 1, we decided to finally show you some numbers on pull outs. The media reports have focused on them and we wanted to give you some numbers that might help put these reports in a broader context. The three tables that follow here will look primarily at whether beneficiaries have access to a risk plan based on the county that they live in.

In 1997 there were 740 counties with risk plans and that grew in 1998 and has shrunk or we expect to shrink in 1999. It is possible that there could be some additions or expansions during '99 but this is what we have up to this point. The percent of counties has grown then from '97 before the BBA rates were originally announced up to '99.

Then looking at the bottom panel this shows what percent of beneficiaries have plans available in the counties in which they live. That has also grown from '97 to '99; it was a big spike up in '98 and has come down
in '99.

Table 2 will take me a little while to get through and explain. The first three columns are dealing with the current situation and the subgroups should add to 100. For instance, in the country 27 percent of the counties are in metro areas and 73 percent are in non-metro areas. If you go across on the metro areas, 76 percent of the beneficiaries live in metro-area counties and 96 percent of those enrolled in Medicare risk plans live in metro areas.

The bank below that, minimum, blend and floor relates to payment update categories. These are payment update categories as they would have occurred in '99 if the budget neutrality had not

removed the blend. There are in reality no blend counties but this shows if the counties were expecting a blend, they're in the blend category.

The same, you'll look at the floor; those are the counties that would have a floor if they could have moved to a blend. In other words, those counties could not have moved to a blend which is why there are more down below that are actually getting the floor than would have gotten the floor if there had been a blend.

How many people did I lose there?

[Laughter.]

DR. HARRISON: Then the bank below that relates to the actual payment rate for '99. The 37984 is the floor. The group above that is those above the floor and below 450. So most of the enrollees are in counties with minimum updates and there's a distribution of where they are versus payment rates with the bulk of them being in the 450 to 550 payment rate category.

The last two columns, the top two numbers say
that 29 percent of the counties in the country have risk plans available and that covers 71 percent of the beneficiaries live in those counties. So for instance,
why don't we take the last column? If you live in a metro area, 86 percent of the people that live in a metro area have a risk plan available in '99. You can see that in the payment rates if you live in a high payment area county, you're much more likely to have a risk plan available.

Ready to move to Table 3. This table looks at counties that either -- the first two columns are counties that had a risk plan in '98, do not have one in '99. So they've lost their risk plan. The last two columns there are those that did not have a risk plan in '98 but a new plan has come on for '99.

So a little more than a million beneficiaries live in counties that no longer have a risk plan in '99 that did have one in '98 and 216,000 beneficiaries live in areas that now have a risk plan that didn't in '98. I think one of the interesting things to note is there is a large erosion here and the place where there wasn't very much erosion, where it was kind of a middling effect is the floor counties where out of the 30 counties that added a plan for '99, 16 of them were in the floor.

So it could be that the fact that Congress raised payments in those floor counties have begun to attract some plans. Now they lost plans as well as all the other counties but those may be for reasons other than the payment rates.

DR. LONG: Scott, of that 1.1 million how many, in fact, were enrolled in risk plans?

DR. HARRISON: It's a little trickier but it seems like it's about 65,000.

DR. LONG: 65,000 out of 1.1 million?

DR. HARRISON: Right, were enrolled.

MR. MacBAIN: Scott, just a clarification, on the floor counties for risk in '99 -- no risk in '98, risk in '99, you've got 16 counties and 87,000 beneficiaries, how
is that different from the 37984, the very last line which is 21 and 140?

DR. HARRISON: Like the previous table, the floor in the middle bank means that even if there were blends, these would be floor counties. Down below what you have is you have some floor counties that would have gotten a blend if the budget neutral adjustment hadn't been put in. Far more beneficiaries lost the particular risk plan that they were in but they were in counties that still have other risk plans.

DR. CURRERI: Wouldn't all the blend, since there wasn't a blend, fall in the minimums?

DR. HARRISON: Yes, they would, that's right. Sorry, that's right. All the blend would actually be minimum updates for this past year.

MS. NEWPORT: The risk for '99 column, that's just the potential beneficiary there or is that -- that's not -- that can't be enrollment?

DR. HARRISON: No, it's the eligible beneficiary population, yes. We don't know the enrollment, right.

DR. LONG: So if I've got this right, generally about 15 percent of all the beneficiaries are in risk plans but in the counties that have lost risk plans only about 5.5 percent --

DR. HARRISON: That would seem right, yes.

DR. WILENSKY: 6 percent.

DR. LONG: 6 percent. So they were under-represented in risk plans.

DR. HARRISON: And certainly, that could be one reason why plans chose to leave those areas.

MR. SHEA: Do we have any information on how many people may have lost their provider, their physician relationship?

DR. HARRISON: No, and I'm not optimistic that we'd have that soon.

DR. WILENSKY: Actually, that's not likely to be the case because presumably, unless there were some providers that only were in a risk plan and had no other patients, these people could always go presumably and then they can go back to traditional Medicare and therefore have access unless their physician only participated in some risk plan. That's not very likely given the kind of withdrawal -- given who these plans were that were withdrawing.

But the problem is much more likely depending on what their other choice is as to whether they will have disruptions and then it makes it more complicated. It depends what choice they make if they go to another risk plan and whether their physician that used to be in the first risk plan is also in the second risk plan.

But technically they could go, the problem is in order to maintain the benefits they'll either have to buy Medigap or go into a risk plan. That will be much harder to sort out by implication what it says to the physician they've been going to but technically they will almost always be able to continue going to their physicians.

MR. SHEA: Right, I think one of the tricky things here is to try to figure out how much disruption there actually is in the actual care system that an individual has. So I didn't think we had the numbers, but I just wondered --

DR. WILENSKY: It really can depend on what they choose next and I don't think we know yet.

MR. SHEA: Right. Our experience though among the active workers when plans change and this kind of thing, it's a very disruptive kind of situation and sometimes people can or sometimes they can't stay with the same physician.

MS. THOMAS: I guess we'll turn to a more general discussion of the chapter now.

DR. NEWHOUSE: This is an issue actually that you didn't bring up. As I understand it, one of the issues in play at the moment is how to do risk adjustment. I'm bringing this up because I'm wondering if we want to take a position on it either in our comment letter or in the March report, we might have some discussion of it. So let me say what I think is the issue here.

One is let me remind people that we have -- the proposed risk adjustment method is going to be the PIP DCGs so diagnosis based on inpatient diagnosis and that the reason we're doing risk adjustment is that we're worried about the potential incentives to select good risks and we're worried about potential stinting of services. Because we're doing the inpatient adjustment we're worried that plans will hospitalize people inappropriately.

So HCFA is proposing three steps, three things at least to mitigate that incentive. One is that they've dropped all discretionary admissions to the lowest category, lowest pay category. Two, they're basing the weights, if you have a diagnosis, on your spending next year. So if you have a heart

attack this year, the additional amount the plan gets is the additional spending the heart attack patient has next year, which, of course, is less. And third, they're not going to count one-day stays.

Now all of those, while they mitigate the incentive to inappropriately hospitalize, they also mitigate some of what we thought we were getting by risk adjustment. Now all that's preparatory to saying what the issue is.

The issue is on one hand HCFA could partially implement this system. That is they could say we're going to pay 75 percent on the APCC and 25 percent on the PIP DCGs. They could also, and these are not necessarily mutually exclusive, although there are some problems with whether the HCFA data system can actually handle both issues as I understand it, they could implement what I'll call corridors. That is they could say, well, we'll risk adjust but no plan can gain or lose more than 2 percent or some, you pick the number.

Now my own view of this is that I prefer the partial implementation rather than the corridors or if we're going to have corridors, fairly broad corridors that go on top of the partial. That's because if you have say plus or minus 2 percent, that's the maximum a plan could gain or lose. Well, if a plan is at -- if it would otherwise have gained or lost more than 2 percent, then all of what we thought we were gaining on the risk adjustment side with incentives goes out the door because it's just like the plan gets 2 percent more, 2 percent less, that's it, end of story; we're back to basically the APCC incentives.

Now if you think the PIP DCGs are just an unmitigated disaster because of the incentive to hospitalize, then that's fine. But that is the issue and I thought we should have some discussion of it.

MS. THOMAS: Joe, before we go into that, thank you very much for giving us a heads-up on that issue. I guess one option before getting into a discussion of it now is having staff do a little bit thinking about it and bring to you a focused discussion of that issue at the January meeting.

DR. NEWHOUSE: Okay. Bill sounded like he wanted to say something anyway.

MR. MacBAIN: I want to jump in anyway on both of those points. I think some sort of buffering makes sense given the flaws in an inpatient-only system to begin with.

DR. NEWHOUSE: By buffering?

MR. MacBAIN: Either a corridor or a phase-in.

DR. NEWHOUSE: It's the which really that's an issue now.

MR. MacBAIN: But the other thing as I read through this instead of thinking about the logic behind eliminating the one-day stays and the elective admissions, if the intent of risk adjustment is to try to -- and the use of DCGs to do that is to find a proxy for measuring the health status of the member and say if this is a rough measure of the health status of the measure, that in turn gives us a way of predicting in aggregate what all people in that particular category should incur in the way of costs in the following year, then it's the diagnosis not the admission that's the important data element.

By eliminating the one-day stays and the elective admissions, HCFA is shifting the emphasis to the admission as being the critical element, which I think makes a bad system even worse.

DR. WILENSKY: The concern that they raise is that given you put an incentive toward hospitalization that not having the one-day stay would at least make it more difficult to game. Now one of the questions is whether or not automatically eliminating one-day stays or looking at the diagnosis and whether or not it was of discretionary or not might be a better way to handle it rather than blanket.

MR. MacBAIN: The question too is whether the cost to plans of one-day stays is greater than or less than the revenue to be gained by notching that up and what happens to the --

DR. WILENSKY: That answer is pretty easy. It's going to be, the revenue is going to be a lot greater by having them in given what we see that these do to your revenue for the next year, which I think is why they put it in its place.

MR. MacBAIN: Are the one-day stays and the electives in the -- I guess they'd have to be out of the database they use to project the rates. So taking them out raises the base rate, the null rate. I'm making that assumption, do we know that that's true?

DR. CURRERI: I think one of the troublesome parts of the chapter, not that the chapter is in trouble but I just don't have any solutions to this, is that it seems to me that one of the most important parts of this is the new system of accounting for the ACRs. We made recommendations last year that this is a critical part and yet we haven't seen any implementation of a plan as to which ACRs, even though a third have to be done each year, which will -- how they'll select those because we made a point I think last year saying probably the auditing of ACRs is not as important in competitive markets as where there's single plans.

So that somewhere I think we -- I just wonder whether we shouldn't repeat some of those recommendations this year and I'd be interested what the other commissioners think about it. But I'm particularly concerned about the funding of this because this seems to be of just -- nobody seems to be concerned of it and if it's going to be accurate, it's going to have to be funded and there's nothing that we've seen so far as to how this is going to be funded and at what level.

MS. THOMAS: We can certainly talk to the HCFA folks and get some more information on that. I think that one of the issues of the ACR is the new methodology is for the year 2000. So my recollection -- we went to a training session of that several weeks ago.

My recollection is that they're really not going to go into the major review and audit until that system is set up. Let me stand corrected by any of the HCFA folks here but that was my recollection.

The new system, just to clarify, is going to be more sort of traceable back to cost accounting data and, therefore, it will be easier to actually audit because I think it's pretty difficult to audit the sort of the types of productions that we used in the past as the basis for the ACR.

The new ACR is going to still be a projection but it's going start with something that you can trace back to financial records and that's going to start for the ACR submitted in May of '99 for 2000.

DR. KEMPER: Just the phase-in approach, I gather, would not be budget neutral. So my question is whether HCFA could do that or whether it would require legislation? That aside I would favor the phase-in. I don't know whether a corridor approach would be budget neutral or not but I guess it wouldn't be.

The reason I say it's not budget neutral is that the risk adjustment presumably is going to lower -- that by itself lowers payments.

DR. WILENSKY: We can look at what was in the actual revenue projections from the Balanced Budget Act. Technically, that ought to be true but there is, as I recall, the CBO has usually been so reticent that I'm not sure they put any savings into the Balanced Budget Act, which means that you may be able to make this change without having it be a coster.

DR. ROSS: I guess I can speak to that a little bit. If it's done administratively, it's not an issue because there's no point of order or anything to be raised against it but it is arithmetically true that if you phase something in you get less of any savings.

DR. WILENSKY: Depending on how they treat it, it need not be an issue although technically it wouldn't cost money.

MS. NEWPORT: I think the budget neutrality issue, I would echo comments I think which are we need to understand exactly what's going to happen there because I think that makes a big difference. Just overall I think that the -- and I realize it's a draft and you folks are still working on it.

I think there's a lot of issues covered but I would suggest maybe thematically making some linkages in terms of it's there but I don't think it's really looked at in terms of the underlying methodology that's in place for payment now is going to have an overlay with the risk adjuster with the flaws that have already been articulated or concerns that have already been articulated as well as then the

decrease in payment that is the adjustment for the education program which is there and then looking at potentially in some markets competitive bidding under the demonstration program, and then possibly from the other MedPAC, if you will, differences in payment recommendations and policies there.

I think that it contributes to, if nothing else, semantically a very unsettling environment in terms of any kind of predictability in what payment will or will not be. I guess that would support recommendations to at least look at alternatives in terms of implementation. A couple of things though I think you need to look at, there is data out on the education program and I know that HCFA has done some tracking on numbers or things like that.

You might want to put that in your paper and maybe you have saved room for that. But one of the things that is in there, which is not an apples-to-apples comparison, is a citation that employers spend $75 per beneficiary. That isn't apples-to-apples because employers have evidence of coverage and all sorts of materials in addition that they gave their employees.

I think that one of the big concerns employers raised with the education program is it may have sent the wrong signal to their employees that somehow they had all of these other choices. So these are stand-alone documents and I think that I would go back and revisit using that as a cost comparison because notwithstanding anything that's put out by the federal government, employers are going to be spending that money anyway.

I think that what is the value added is what we should look at, not necessarily that that's what the government needs to spend or not spend because heaven forfend we should be against education at any level. That's not something we need to do.

But I think that one of the things that is very almost -- and I understand your caution in terms of recommendations at this point, I looked at those and I thought maybe we could be more specific, but the fact is it is early days.

I just do think that we need to make sure that the linkages are made between every part of this program right now and the potential costs in terms of increased beneficiary cost, increased out-of-pocket payment, and potential lack of choice that may go forward if this isn't done in a sort of steady way, in a very insightful way.

The last piece of this has to do with the
year 2000 and the risk adjustment. HCFA will be coming out with an estimate in March and everyone seems to be thinking that that estimate is just an estimate and it won't reflect in the packages that beneficiaries are offered for the
year 2000.

The fact is that estimate becomes what plans will have to use to project it which goes to your ACR comment. It is very difficult to be accurate on a projection and an estimate especially when we have identified some real profound concerns with that. I think the other part of this goes also to that which is in this HCFA is saying they're going to maintain the level playing field. I think that that sort of doesn't -- while it sounds articulate in terms of what they need to do I think it doesn't necessarily create a level playing field for the beneficiaries and we need to really take a look at how this plays out and what kinds of options are available.

I think I'm just urging sort of a thematically tying this up a little bit. I know, Gail, you want to say something so I'll defer to you and then maybe come back with some comments.

DR. WILENSKY: I just had some specifics that may get at least some of the points that you raised more generally.

On page 14 there's a discussion about the challenge to the policy of flexible benefits and that what used to be allowed now may not be in terms of having to have, in the future, the same package or the same price/ package combination throughout the service area, even though there may be very different payment levels throughout the service level.

I don't know whether we have taken a position on that, and that just strikes me as an invitation to more trouble. I mean, to demand that you provide a package/price combination that is uniform in the face of different payments by the payer, is going to do what I think is suggested.

The Commission is concerned that beneficiaries in low payment counties may have decreased access as a result. That strikes me as something, depending on how other commissioners, feel might be a recommendation. It just does not make good sense to take what the government has recognized as justification for differential payment and say ignore that and eat the difference.

MS. THOMAS: You did make a recommendation to that effect in the comment letter and you certainly could --

DR. WILENSKY: But I mean in terms of the report as well. There is a second issue with regard to deeming on page 21 where there was -- BBA gives HCFA the authority to allow plans that have been accredited to be deemed compliant and then there was a question raised as to whether there may be a conflict of interest because you may have somebody on the board or of the body that comes from one of the organizations that would be accredited.

Is this, what is being proposed here, comparable to other deeming that HCFA does? Or you don't have to answer it now, if you don't want to, but it would seem to me that we ought to address this issue within the context of whether or not this is comparable, more restrictive or less restrictive than what goes on in the other areas where HCFA allows deeming, which is both for the hospital and for nursing homes.

There's a history that we can turn to that unless there's good reason that HCFA ought to follow its own precedent I would think unless there's some good reason not to.

MS. THOMAS: We'll follow up on that.

DR. WILENSKY: A final area that I think, I guess I didn't agree how it's presented and I just wanted to at least have you think some more about the rationale that led to the statement, had to do with whether or not we are likely to see -- it's at the bottom of page 25 and the top of 26, and it's how organizations may respond in terms of lower Medicare payment and higher cost and whether the fact that many of the risk plans are for-profit entities would mean that they would continue to serve in markets where they're losing money.

The comment was made, or at least the inference was, that because these are for-profit entities they probably wouldn't do it because their stockholders wouldn't allow it seemed to me somewhat gratuitous because even if they were not-for-profit, it's unlikely because it would be unfair to say the under-65 members to expect them to cross-subsidize the over-65 members.

So the fact is if you're going to count on cross-subsidies in order to get things available for seniors, you're likely to ask for trouble because probably it's not going to happen. I don't really think it's an issue of the for-profit or not-for-profit.

DR. NEWHOUSE: I'll pick up on a couple of those points. The last one I think the point you want to make is if the commercial market is competitive, which we think it generally is, this won't be possible.

Then on the first point that Gail made that with payment being county specific and benefits being broader than counties, that that's asking for trouble. I agree with that but my understanding is that's in the law, that HCFA can't change that on its own; is that correct?

So this becomes a recommendation to the Congress?

DR. HARRISON: What HCFA has some authority on is accepting the plan's definitions of service area and so this year they've been using segments, where a plan, as long as they submit a separate ACR has been able to segment their service area. I think a final decision hasn't been made for 2000 but it sounded like that may continue.

DR. WILENSKY: I think that it's a good point, not that we shouldn't or haven't already today raised issues that would require Congressional action as opposed to HCFA administrative action but I think we need to be clear when we make a recommendation that this is a recommendation that would have to be voted on by the Congress as opposed to a recommendation that HCFA could institute administratively. Janet, you had some follow-on?

MS. NEWPORT: Just some follow-on, and this goes to -- I think Joe raised it earlier in terms of systems issues for HCFA on the -- I guess it applies more readily to the risk adjuster than anything else. Even if there was a perfect risk adjuster and everybody was in agreement, I'm really concerned given some recent information that HCFA's systems ability to administer an individually based risk adjuster is very problematic. This is besides the Year 2000 compliance.

There's an issue that came up with the working aged in terms of being able, right now some of you may or may not know there is in essence a risk adjuster for working aged. My understanding is that once someone is on this system as working aged, even though they then retire truly, that will not be turned off. It can't be turned off now.

This is a question, does this speak to a systems problem that is endemic to their systems right now and would make appropriate implementation of risk adjuster whether it's phased-in or there's corridors or there's not a possibility? Does it jeopardize? I'm asking this as a question, I do not know the answer to it.

So I think it's something that needs to be considered as well and I don't know where you -- how quickly you can determine that.

Then there's a notion in the paper, too that is in a couple of places, it talks about one of the things that the plans can do in order to maximize I guess their income or minimize their losses is enroll healthier enrollees. Technically that's illegal so I guess I wonder how we do that.

DR. LONG: A question about the role and intent of Table 1 following page five. As I appreciate we're playing two simultaneous what-if games in the table, one has to do with how the extent to which Medicare per capita spending might grow or might have grown, which is the first column. And then the second column, which is I gather saying what if the statute had been different? Those seem to me rather different kinds of simultaneous what-if games.

If the purpose is merely to illustrate how the arithmetic of the statute works, that's one thing. If the intent is to suggest that Congress should have done something differently or should change something they've already done, it seems to me that's a very different intent and I'm not exactly clear on what we're doing.

Are we saying that if Congress went back and changed the minimum, lots of counties would get more than the minimum because blend would kick in and, therefore, it's a good thing for Congress to do or is it much simpler than that, we're simply saying here's how the existing arithmetic works?

DR. HARRISON: I was trying to show how these two forces came together to get rid of the blend counties and what really happened was that Congress set a 2 percent minimum but probably they were thinking that the updates were going to look more like 6 or 7 percent as they had in history and so 2 percent seemed pretty low. It turned out that the updates have been much lower, close to 2 percent and so those two factors combined to get rid of the blend.

DR. LONG: I think we should be clear that this is not a back-door recommendation to change the minimum.

DR. KEMPER: I just wanted to pick up on a couple of things. I agree with Gail on the being more forceful with actually having a recommendation on the geographic boundaries.

Also both Gail and Janet mentioned the page 25 discussion about organizational responses and it just seems to me that the assumption ought to be that the plans are already doing what they can in all these areas; why should that change that?

A couple of other comments; I had a sense that I think goes beyond the editorial that this has kind of an ominous tone to it as opposed to a tone that BBA made substantial changes in the law and particularly when those interact, they're having major effects that we're observing.

Secondly, I think that particularly when you get to the discussion of the purpose of Medicare+Choice, and I guess it goes through the chapter, the problems are attributed to Medicare+Choice changes, whereas I think a number of the changes really would have happened even if there weren't Medicare+Choice, so there's kind of a mixture of changes going on and I think it would be useful to distinguish that.

I mean risk adjustment might well have been done in the absence of Medicare+Choice as well as some of the other things.

DR. WILENSKY: We certainly had recommended it even in the absence of Medicare+Choice.

DR. KEMPER: So all these changes are being made but only part of them are really the result of the move toward offering more choice.

Then finally, on the monitoring it seems to me it would be useful to target the monitoring, not have the sort of AWACS scanning the environment but zero in on areas where because of law changes we expect to have problems and some discussion of how that monitoring might be targeted would be useful.

DR. NEWHOUSE: A comment on the discussion on page 24 about rising prescription drug prices, a couple of comments actually. One, you say that the managed care plans are likely to respond to the drug price increases by reducing the amount of drug coverage but it seemed to me they could respond on all sorts of dimensions; it wouldn't necessarily be just with drugs.

Then also, you said if they offer less generous benefit packages, just kind of following on, well, there's drug prices, there will be less generous benefit packages. Then if there's less generous benefit packages, you say the enrollment rates may slow, but if the less generous benefit packages are driven by the drug price increases, those presumably will also feed into Medigap premiums or if people don't have Medigap for drugs, then they'll face the drug price increases on an out-of-pocket basis.

So it wasn't clear to me that the group that it would drive would be the group that had employer-provided Medigap where it hits the employer but for the rest of the people, one way or another they'll face the drug price increases so that you may want to reword that.

Then finally, you said if we set the rates and if there's increased drug costs, plans may pull out. This is over on page 30. It never has quite been clear to me why a plan would pull out as opposed to raise its premium, if they could raise the premium. There's a lot, at least there have been a lot, of zero premium plans around and I've never quite understood that logic. I mean I admit that plans do seem to be pulling out.

DR. WILENSKY: I think that this is something that we may not see in the future. There had been up until this year what I regarded as an irrational assumption that the premium was either zero or they would lose the market share.

My sense was when the plans wanted to do some renegotiation with HCFA in the fall, that they had come to the wiser conclusion that there was a big difference between zero and the cost of the Medigap premium and somewhere in between was not necessarily off the table. I think that we will at least see a positive price that can be justified through the ACR as something that plans will continue to be considered in the future.

DR. NEWHOUSE: I was reacting to a sentence that said if most organizations are pulling out because of increased drug costs, it's a little hard to believe that that's why they're pulling out.

DR. WILENSKY: I agree. I would like you to check the numbers, I don't believe the numbers you cited in there. I certainly don't believe them as drug costs.

MS. THOMAS: The drug numbers?

DR. WILENSKY: Yes, so just go back and check and make sure. It would be interesting to note whether these plans use formularies which employer plans normally have because again, if it's as concentrated in one area as you're suggesting -- although again I think that has got to be total spending not price increases that you're citing, but even so I'm not sure I believe the number as a volume -- it's unclear to me why some formularies aren't being used if it's as focused as you're suggesting. So I'd be curious as to whether that's going on.

Finally, for me there was, in your discussion about the use of five states for education purposes, it seemed to me that there was sort of a negative flavor in there whereas -- I don't know, it struck me that what HCFA was doing was perfectly reasonable which was to try out on five states a strategy for education.

There was an interesting article in the paper today that the call centers were receiving far fewer calls than they had expected at least for right now. They're not sure exactly why that's going on. But it struck me that going out and doing something for five states rather than 50 states, when you're not sure you've got it nailed down yet, is reasonable.

Again, as I read it I got a negative flavor that that really wasn't such a good idea. So if you didn't mean that then I think you ought to look at the wording. And if you did, you ought to have more rationale why you think that was a bad thing.

DR. MYERS: I would just add on to the Chair's discussion regarding formularies. There are other options too that are being considered short of dropping the benefit that I think are going to gain a lot of momentum: mandatory generics; therapeutic substitution where one drug is substituted for another of like properties; mandatory mail order for chronic drugs which saves administrative fees; and differential copays for generic versus trade drugs; and then finally, new classifications of drugs.

One that's been talked about a lot are lifestyle-related drugs that would probably have a different copay or different payment structure. All of those things are being looked at and/or implemented and I would suspect that many would choose to use one of those strategies short of eliminating the benefit or prior to eliminating a benefit.

DR. NEWHOUSE: You have a rather eye-grabbing number in here that between the middle of '97 and the middle of '98 drug prices rose 22 percent.

DR. WILENSKY: That was the number I was referencing that I didn't believe.

DR. NEWHOUSE: With the major increase due to prices of psychotherapeutic drugs. My recollection is actually there's one generic psychotherapeutic drug that accounts for quite a bit of that but whether that's right or wrong, the general point I wanted to make is that that drug price index is a general index and what I don't know is how well it reflects the drug market basket that the elderly purchase. And if there's anything known about that, you might put that in.

MS. THOMAS: We'll put in some more information there to the extent that it's --

DR. NEWHOUSE: I doubt that there is an index that is elderly specific for drugs.

MS. THOMAS: Right, but to relate it to the elderly population.

DR. MYERS: Just not to be picky but drug price indices, you have to make sure you're talking about drugs that are outpatient or consumer versus all drugs. Many drugs are inpatient that the consumer would never get access to through a pharmacy. So you have to be careful which one you're looking at.

DR. CURRERI: On the drug index, that's overall drug index increases and it was my impression that the large managed care organizations had a lot of market power involving volume buying and so forth. So I'm not so sure that the 22.3 percent has anything to do with what actual large managed care organizations actually do pay for drugs.

MS. NEWPORT: In one of our areas our average cost per scrip is $64. We have a $5 to $15 copay depending on the area. So you can do the math on that. It may be helpful to talk to a couple of companies but I think that it's a big expense and I think part of offering it is it helps with your utilization, people will take their drugs if they're not paying that much out-of-pocket for them.

So I think there is a cost benefit to that and I'm not going to slide by that but I think it's a pretty expensive benefit overall.

DR. WILENSKY: Thank you. We'll move to the second section on hospital costs.

MR. GUTERMAN: Good morning. This commission and its predecessor commission ProPAC had a great deal of interest in trends in hospital cost payments and margins for a variety of purposes, mostly as applied to making decisions about changes in hospital payment policy.

For the last couple of years we've had data through 1995 because of changes that were made in the Medicare Cost Report Form and in processing related to that and rules for time frame for submission of cost reports. Now, we have new data that covers 1996 and we have partial data on 1997 that come from cost reports for about half of all the PPS hospitals and we'll be presenting you with data on that.

Most of these overheads are in your mailing books but there are a couple of new charts at the end so I hope to review what was in your mailing material briefly first and then focus on the new material. First, I ought to say that even though the 1996 and partial 1997 data are new, in a sense they're old because they still cover the period prior to the implementation of the Balanced Budget Act of 1997, but they do sort of fill in the baseline for evaluating what the potential consequences of the changes in the BBA will be.

In the first overhead, I present the trend in the annual PPS operating updates. The top line there is in each year the amount by which the rates were increased, is done on a fiscal year basis and you can see that they've gone from a peak of 4.7 percent in 1990 to a zero percent update in 1998 and then a .5 percent update that took effect on October 1st for fiscal year 1999.

Each year the update is legislated in terms of the hospital market basket, which is the measure of the cost of the prices of inputs that hospitals purchase in producing their services. The bottom line in this overhead shows the trend in the updates relative to the market basket forecast for each year and you can see that actually when you look there, actually the updates in the last couple of years when they're averaged out, look very similar to the trend in the previous period.

In fact, if you look at the zero percent update in 1998 as compensation for the sort of blip in the update in 1997 that resulted from the failure to agree on a balanced budget legislation in earlier years. The average update relative to the market basket for the last three years has been market basket minus 1.7 compared to market basket minus 2.0 in the previous three years. So you find the updates a lot more comparable with previous history.

In the next overhead, you really see two points. One is that if you compare the dotted line, the lowest line there, that's the annual update accumulated over the time period since the beginning of PPS. And if you look at the solid line, that's the increase in the actual payments per case since the beginning of PPS. You see there's a large discrepancy between those two.

By 1997 actual payments per case had increased by 131 percent since the beginning of PPS while the cumulative update was only 42 percent. That gap is accounted for primarily by three factors. One is in the first year of PPS, there was a very large increase in

the payment rates due to the use for development of the federal rates of unaudited hospital cost reports and that caused the big jump in payments above what the update was.

You've also got the cumulative effect of increases in the Medicare case mix index which reflects the distribution of cases among DRGs and directly reflects the amount of payment that hospitals receive for each case. You've also got the effect over these years of policy changes that the Congress has put into place, several of which increase the total amount of money in the payment pool for PPS.

The second point that this overhead illustrates is the relationship between payments per case and cost per case over the time period. You see that although payments per case have for most of this period risen at a fairly moderate but steady rate, cost per case were rising a lot faster in the early years of PPS and eventually exceeded payments per case in the early '90s.

Then in the last several years you've seen a sharp turn around in that trend as you've actually had a nominal decline in cost per case in hospital inpatient services.

DR. CURRERI: Why has that occurred?

MR. GUTERMAN: Why has that occurred? We'll get to it more later. My brief description of the process is that there's been a lot more pressure from private payers, particularly managed care plans, and hospitals have responded by holding their cost growth down.

Now how they've accomplished that actually has been in other analyses we've done pretty much reflected across the board in sharp reduction in the growth rate of wages for hospital employees, other changes in the way hospitals provide care that Jack will get into after lunch today. But they have sharply reduced the growth rate.

In the next overhead you see that more explicitly. This shows the annual change in Medicare hospital inpatient PPS operating cost per case. And you see that the partial data for 1997, which is based on a cohort of hospitals that have cost reports both in 1996 and 1997, and we have about half of all of the PPS hospitals for 1997.

It indicates that that year will be the fourth consecutive year in which there's been an absolute decline in operating costs per case in PPS hospitals.

In the next couple of overheads, you see that this decline has been pretty much across the board, although it's played out somewhat differently for different groups of hospitals. Hospitals in large urban areas have experienced the steeper decline in the growth in costs per case than in rural areas, where there's been actually a slight increase.

But still the striking thing is that if you look in these four periods, which I've basically grouped together based on the overall trend in hospital costs per case, that the last five year period has shown pretty much an across-the-board sharp decline in the growth rate of hospital costs per case, even in rural areas where there's not as much managed care.

We can skip the next overhead and go to the ownership category. This is very interesting because you see that the proprietary group here has had a trend that looked more different from the average than the other groups. In the first year of PPS there was a lot of trepidation among hospitals about the amount of financial pressure they would face from this fixed-price system and proprietary hospitals kept their cost growth well below the historic rate but also well below the average for all hospitals.

In the late '80s you found that hospitals realize that number one, they had very high PPS margins to start; and also, that they could generate more payments from the private sector to support higher cost growth. And proprietary hospitals actually had a slightly higher cost growth, but basically comparable to the other ownership groups. And then when the pressure started to get turned on in the early '90s, you see that proprietary hospitals appeared to have responded more sharply in controlling their costs than the other ownership groups.

How this plays out in margins is shown in the next overhead. This is a little different than the figure that was in your mailing because we've since done some estimating of what PPS margins

would be in the current fiscal year. The latest data we have is the 1997 data, which are preliminary and will change as more hospitals come in.

But based on that information and information on what we know about the updates for 1998 and 1999, and what we know about cost trends from the data from the American Hospital Association National Hospital Panel Survey, which is a much more timely indicator of payment and cost trends for hospitals overall, we're estimating that in 1998 and '99 the PPS margin will level off and drop somewhat. Our current estimate of 1999 is 15.7 percent, which is .4 percent less than the latest data for 1997 but somewhat higher than 1996.

That's even reflecting the changes in the Balanced Budget Act, which include the change in the definition of the transfers for payment from hospitals and the reductions in indirect medical education and disproportionate share payments.

Again, this trend in margins is primarily driven by the change in hospital cost growth.

In the next overhead, you see an indicator of the fact that this trend -- again we're back through 1997 we haven't done a hospital level estimate of what the current margins are. It's too difficult to do at the hospital level. But you see that over time, the solid line in the middle there is the median hospital margin, PPS margin, and the top line is the 75th percentile that is the margin above which 25 percent of the hospitals stand. The bottom line is the 25th percentile, which is the margin below which 25 percent of the hospitals are.

You see that the trend there reflects the trend in aggregate margins. That is the distribution in margins across hospitals has basically floated along with the aggregate amount of money in the system relative to costs. There certainly are a number of hospitals that perform worse than average. There are an equal number of hospitals that perform better than average. In fact, there was a spread in the distribution in the early years of PPS, but since the early '90s, that spread has been fairly constant, the distribution has been fairly constant, the distance between the 25th and 75th percentiles.

MR. MacBAIN: Stuart, do we have any sense of how much turnover there is in the group below the 25th and above the 75th percentiles year to year?

MR. GUTERMAN: In terms of closures? Oh, hospitals hopping around?

MR. MacBAIN: If you were to look at this cohort above the 75th or below the 25th year after year after year, how much turnover would you see in that group?

MR. GUTERMAN: There's a fair amount of bouncing around from year to year. Single year margins for individual hospitals are very hard to use as an indicator of what's going on because you'll find, because of accounting treatment of certain costs, you find from one year to the next that a margin can be low one year and high the next. What's remarkable is how across the whole group of hospitals you have this stability.

One thing we did look at was from 1995 to 1996, about two-third of all hospitals that we had cost reports for in both years had higher margins in 1996 than 1995. So there doesn't seem to be any random patterns. But for individual hospitals there's a lot of bouncing around.

DR. WILENSKY: Is it both the operating costs and the revenues or is it the operating costs are relatively stable and the revenues that bounce; do you know?

MR. GUTERMAN: On a per case basis, you would expect that the revenues would be fairly stable because the rules are relatively similar from one year to the next, but no, I haven't looked at that separately. But I would expect that it would be the costs that driving those bounces because of the leeway for treating accounting costs and assigning them from one year versus the next.

In the next overhead, you see another aspect of this, and this is the percentage of hospitals with negative PPS margins. You can see again that, in 1991 when aggregate PPS margin reached its nadir, the proportion of hospitals with negative margins reached its peak. And then it since declined sharply and steadily since then.

In 1997 would show about 23 percent of all the hospitals that we have data for with negative PPS margins and that is the lowest since 1985 when it was also in the low 20s.

DR. LONG: Stuart, just to reiterate Bill's point now on this slide, A, it's encouraging that this is a low point for a very long period of time. Nonetheless, it is, as someone pointed out, about one out of four hospitals. I would worry about that if I knew that those were the same one out of four hospitals for several years in a row. And I would be largely unconcerned about it if I knew that there was a 90 percent turnover in those that were in negative margins over a period of a couple of years.

MR. GUTERMAN: We can definitely look at that and come back with some information. The information I have is from a study that ProPAC did a number of years ago now on winners and losers under PPS. We tried to get consistent winners and consistent losers and found that there certainly were a lot of hospitals that were consistent winners or consistent losers. We also looked at why they were, which was the purpose of the study.

But we also found that it was hard to nail some of the hospitals down because there was a lot of bouncing around between quartiles and the distribution. But we can take a look at that and update that information.

MR. MacBAIN: The other part of that question is who are those hospitals? Is there a group of say rural government-owned hospitals that are chronically showing a negative PPS margin or a certain set of urban teaching hospitals or something like that?

MR. GUTERMAN: Off of other sort of impressions I get from working with the data, there probably are two groups of hospitals in any segment of the distribution. One is hospitals that have not been able to reduce their costs as much as other hospitals and therefore have lower margins. And those may be consistently in the lower group because of factors that they face and others that have aberrant years because of again treatment of accounting costs and things like that. But I can nail more information down on that and come back to you.

Of course, the Medicare PPS margin, as has frequently been pointed out, is not the bottom line for the hospital. So we also look at the total hospital margin, which reflects all of the economic activity for the entity. First again, we have data through July of 1998 from the AHA panel survey. What we see here is the trend toward more pressure from the revenue side, matched by more constrained cost increase seems to have been continuing since 1998 would make the fifth straight year that both revenues and costs were at or below a 2 percent rate of increase.

In the first seven months in 1998, revenues per case rose by only .7 percent over the same months in the previous year and costs per case rose at .8 percent.

On the next overhead, again you see how this plays out. In contrast to the data in the previous overhead, these data are from the Medicare cost reports. What we get from the cost report is that in the last several years, even in the face of more pressure from the revenue side, hospitals have succeeded in maintaining and even improving their overall financial status.

As we'll see down the line, it's been pointed out to me that some of this might be reflecting the stock market and investment income on the part of hospitals. But a lot of this is just pure and simple the fact that hospitals have constrained their costs so successfully that in the face of other policy changes and other changes in the revenue environment they face, they've actually been able to maintain their total margins.

DR. LONG: Just to be clear, this includes all other outpatient activity?

MR. GUTERMAN: It includes outpatient and everything else, both patient care and not patient care, that are considered part of the entity's financial statement.

DR. WILENSKY: Looking at the annual change in hospital total revenues and expenses per adjusted admission from '91 to '98, it looks like they are pretty comparable. And yet you have this changing margin. Is it something about the per adjusted admission that's driving it?

MR. GUTERMAN: It may be, but the denominator in the per adjusted admission are the same, so this should reflect the relative increase in total payments and total revenues and total costs.

DR. WILENSKY: This seems like a real different picture.

MR. GUTERMAN: Yes, there's a little bit of difference. One is that the panel survey is a sample of hospitals and another is that the panel survey applies to different periods in general than the Medicare cost reports.

Another might be the care that's taken in reporting the data, but the cost reports that the total margin data are taken from is the section of the cost report that should come from the hospital's financial statement.

DR. WILENSKY: This looks like a really different story line.

MR. GUTERMAN: We don't have access to the individual hospital data from the AHA so we can't reconcile the differences on an individual hospital basis.

MR. JOHNSON: While you mentioned the non-operating revenue, do you have any charts or statistics that would break out these, in terms --

MR. GUTERMAN: Yes, we do, actually, toward the end of the presentation, so we'll come back to that.

MR. JOHNSON: Is that also by payer?

MR. GUTERMAN: Yes. We have trends by payer.

MR. JOHNSON: But not in the presentation?

MR. GUTERMAN: Yes, we'll get to that at the end.

Again, the next overhead shows the distribution of total margins there, and actually the distribution of total margins has narrowed since the late '80s, although it generally reflects the trend in the aggregate total margin.

In the next overhead, again the proportion of hospitals with negative total revenue margins. You see that the proportion seems to be holding steady for the last several years, between 21 and 22 percent of all PPS hospitals had negative total margins in 1996 and again
in 1997, apparently. And that's sort of been the trend lately. But if you notice the earlier years, that's below the proportion of negative margins in any years since PPS began.

Let's skip the next three overheads. What the next three overheads that you're not going to see say is that for individual hospital groups you have a large contrast between PPS and total margins, but we'll get back to that in more detail in a minute.

The Commission has been asking for a better picture of what Medicare does to hospitals -- maybe that's not the best way to put it.

[Laughter]

MR. GUTERMAN: What Medicare does to hospitals overall, as opposed to just for the inpatient services or even the outpatient services separately. I have to correct one typo, this overhead is for 1980 to 1996, not 1986.

What we've done here is plot the payment to cost ratio which is analogous to a margin. It's a more direct ratio between payments and costs instead of calculating margin, but there's a one-to-one mapping here. And if the payment-to-cost ratio is over 100 percent, the margin is positive. If it's under 100 percent, the margin is negative.

What you see here, the dark line that starts out in the middle, is Medicare. It ends up in the middle, too. You see that in the pre-PPS period, the advantage of these data -- and again, this comes from the annual survey of hospitals, and we've worked with the AHA to analyze these data since they don't make the data generally available for privacy considerations. But we've been working on them to analyze these data for a number of years.

You see that in the 1980 to 1983 period, the Medicare payment-to-cost ratio was below 100 percent. Now this might strike you as strange, since during that period Medicare generally reimbursed costs for hospitals. But what it reflects is Medicare allowable costs and these numbers reflect all of the costs that are allocated to Medicare patients. We allocated costs to each payer by the charges that were rung up on the bills for the patients.

DR. NEWHOUSE: Is this just inpatient?

MR. GUTERMAN: No, this reflects all of the hospital business, including inpatient, outpatient, and any hospital based post-acute care that's covered by Medicare that is considered part of the hospital economic entity.

So the first point to notice is that Medicare was under 100 percent, even in the good old days of cost reimbursement. With the beginning of PPS, the very high PPS margins drove the Medicare payment-to-cost ratio over 100 percent in the early years. And then, as Medicare PPS margins, the inpatient PPS margins, fell the Medicare payment-to-cost ratio fell also to a minimum in 1991 of 88.4 percent. So in 1991, Medicare was paying 88.4 percent of costs.

And then, along with the PPS inpatient margin, the overall Medicare payment-to-cost ratio has risen in the last several years. And as of 1996, that payment-to-cost ratio was 102 percent in the aggregate. That reflects where Medicare payments stand in the aggregate relative to the total costs allocated to Medicare patients. And that includes both Medicare allowable costs and other costs that were incurred in the treatment of Medicare patients as reflected in their charges.

The thing to notice here is that 102 percent indicates that the overall Medicare margin for hospitals is a lot lower than the 16 percent that we're showing, but it also, remember, is 6 percentage points higher than when Medicare was on a cost reimbursement basis. So it's not exactly that the Medicare margin is 2 percent. It's actually, even interpreting it at face value, is more like 6 percent above where hospitals were when they were being reimbursed for all Medicare allowable costs.

MR. JOHNSON: Even though they weren't being reimbursed for full costs, it's 2 percent above full costs?

MR. GUTERMAN: Right, it's 2 percent above full costs. One might surmise 6 percent above Medicare allowable costs.

The other two lines on here reflect the other major payment components, private payers in the aggregate. We have no way of breaking them out, even between indemnity and managed care. But in the aggregate, if you look at the private payer line, which is the highest line there, you see that the shape of that line almost is the mirror image of the Medicare line.

What's been going on is that in the early '80s -- private payers have always paid a premium above costs for their patients, presumably this premium went to subsidize other activities of the hospital. In 1980 and 1981, the private payer payment-to-cost ratio was 112 percent while in 1982 through '86, that rose to about 115 or 116 percent.

And then, as Medicare crunched down on its payment rate increases, relative to hospital cost increases at least, the private payer payment-to-cost ratio rose steadily until in 1992 it reached a peak of 131 percent of costs. And then what you see in the last several years is the increased resistance on the part of private payers to continued cost increases, and you've seen a decline in the payment-to-cost ratio from 131 percent to 122 percent, even in the face of lower cost increases.

So that decline of 131 to 122 percent doesn't reflect pure payment declines, it actually reflects payment declines that were that much greater than the decline in cost growth that you saw during that period.

DR. WILENSKY: What is the intuitive explanation as to why the private sector is being such a patsy, and to pay 130 percent or 125 percent?

MR. GUTERMAN: I think you'd be better off asking a private payer.

DR. MYERS: What was the question again?

DR. WILENSKY: Why are private payers being such patsies? This doesn't intuitively make a lot of sense, that you would have that kind of thing.

MR. MacBAIN: If you look at the time frame here, up until about the '92-'93 range, you really didn't have a lot of pressure from private payers contracting directly with hospitals and starting to get involved in adopting DRGs and pushing down on per diems hard.

DR. WILENSKY: I'm thinking more about post-'92.

MR. MacBAIN: That's really where it begins and, as Stuart said, because this is a ratio, as the commercial ratio comes down, that means that payments are being driven down faster than costs are coming down. If you go back to the cost per case graph that he presented earlier, that shows cost per case begins dropping off pretty significantly in '92, for the private pay margin to drop off even faster means that the price levels are coming down significantly.

I think, looking to the future, that's significant because the rise here, beginning in '88 or '89, clearly is a response to what's going on in Medicare and Medicaid. Having been involved in some of those pricing decisions, at least in one institution, that was exactly what was happening. That can't happen now to nearly the same degree.

And so, if you try to extrapolate beyond '96 and estimate what the combined impacts of the Balanced Budget Act are likely to be, inpatient margins but particularly on outpatient margins and SNF margins for those hospitals that have hospital-based skilled nursing facilities, you can see that line of little square boxes start to drop off again but without the corresponding compensation on the private pay side. So there could be some problems.

DR. WILENSKY: If these numbers are accurate, though, it's a pretty big spread, at least as of now, to the extent the numbers are accurate.

MR. MacBAIN: And that squares with my own experience, seeing the numbers inside of an institution.

DR. MYERS: I just wanted to answer your question from one perspective. I think it's only been recently that employers have become interested in the economics of what's actually happening. And this implicit subsidy is now, for the first time, really being questioned.

Secondly, I think employers put their eggs in the managed care basket for many years, thinking that that was and should have been the primary strategy. I think there's some questioning of that now, as well.

I don't expect that this will remain unnoticed.

DR. WILENSKY: The differential is so great. I mean, this isn't like the equations you need, you would think, to be able to see something like this.

MR. MacBAIN: It feels right.

DR. WILENSKY: I'll take your word for it. It just seems like an awful big difference.

MR. GUTERMAN: But again, remember the decline from 131 percent to 122 percent understates the decline in the payment rates because costs are --

DR. WILENSKY: I understand that.

DR. KEMPER: Stuart, can you say anything more about the discrepancy between the 102 percent versus the 15 percent inpatient PPS margins? I mean, is the outpatient side so different or is it different data sources? It just seems so far --

MR. GUTERMAN: Some of it undoubtedly is different data sources because it always is, but we've seen data on Medicare payments relative to outpatient costs that show that payments are substantially lower than the accounting costs allocated to the outpatient sector. I don't have a good feel for what proportion of non-allowed costs occur on the outpatient side relative to the inpatient side.

But there's that, and then there's the other hospital-based care that might be provided that again, in terms of accounting costs, are limited. Both skilled nursing and home health are paid for on a cost basis but with limits of some sort. And also, PPS-excluded facilities would be in here, too. A rehab unit would be reflected in here, too, that are also paid with limits.

DR. KEMPER: It seems like some effort to try to make sense of the discrepancy would be useful.

MR. GUTERMAN: If we could break out the different kinds of services, it would be a very useful thing but that's very difficult to do.

DR. LEWERS: Stuart, do these costs and payments include all costs, all payments such as GME? Is the GME thrown in here or is it wiped out?

MR. GUTERMAN: Yes, it would be in there.

DR. LEWERS: It is in here?

MR. GUTERMAN: That's what I'm told. I'm not sure but I can check.

MR. ASHBY: It's definitely in there.

MR. GUTERMAN: It is in there.

MR. JOHNSON: Stuart, one other thing, looking at this chart and thinking about the question that Gail asked about the differential between private pay, one thing that's not listed in this chart that's listed in the chart book from this summer --

MR. GUTERMAN: We'll get, actually, to a graphical representation of that in a minute.

MR. JOHNSON: I was going to say the other thing that's not shown here is uncompensated care, which is an offset against some of this stuff. There's no line for that here.

MR. GUTERMAN: Right, because this is just the payment-to-cost ratio. In the next overhead, however, what we've done is translated net revenues, which we've been calling gains and losses. And it is represented, as Spencer said, in the July chart book, data book.

What we've done is translate the net revenues into contributions to margins, essentially, which is just net revenues as a proportion of total hospital expenses. So net revenue for each payer as a proportion of total hospital expenses. So if you add up the gains or losses by payer, you get the hospital's or the group's total margin.

You can see here the trend in that, and at least for Medicare and private the shapes are similar. The difference here is that we've lumped Medicaid, other government programs, and uncompensated care into other patient care and that's what you see in that other patient care category here. You see that that's been sort of steadily at around minus 5 percent, the bottom line.

The other differences, the next to highest line there, which was level until the last couple of years and then has sort of sloped up, is the non-patient care category. You see that non-patient care has made an increasing contribution to hospitals' overall bottom lines.

DR. CURRERI: What is non-patient care?

MR. GUTERMAN: Everything a hospital does that's not directly related to patient care, parking lots, gift shops, laundry service.

MR. MacBAIN: Stuart, maybe you said this and I missed it, but how did you calculate the gains and losses by payer in this?

MR. GUTERMAN: What we've done for the last several years with the AHA is that we take the -- the AHA annual survey has gross revenue charges by payer and also payments by payer. Presumably, if it works right -- and again, different hospitals may treat it different ways. But if it works right, if a patient is classified as a Medicare patient or a Medicaid patient or private pay, all of the charges on those bills and all of the payments that are received for those bills are put in the Medicare bucket.

And then what we've done is at the hospital level we know total expenses and total charges, and what we've done is reduce that charge figure by the expense-to-charge ratio to get an expense

figure for the group. So to the extent that there's different charges for different patients, and there probably is somewhat, that would be reflected in here.

These are the aggregates over time. In the next couple of overheads we show how that plays out differently for different groups of hospitals. What you see in this overhead is by location, that's urban versus rural hospitals. You see that urban hospitals have somewhat higher Medicare margins than rural hospitals, but that rural hospitals generally make more money on private payers. This again is net revenue as a percentage of total hospital expenses, so this is the contribution to total margins from these different categories and you can see that for other patient care, which is really driven by Medicaid and uncompensated care, and we've counted any state and local subsidies that the hospital gets against the uncompensated care that they provide.

You see that other patient care contributes a lot larger loss to the urban hospital than the rural. And then there's the non-patient care. So all that plays out, all that contributes to how the groups of hospitals function. And of course, for individual hospitals you see a much wide variety of contributions to the bottom line.

What this reflects is three things. One is how generous each group of payers is -- well, four things, actually. How generous a payer the group is, but that's made up by the mix of payers in each group. Because for private payers you can face very different mixes of the private payers in different locations for different hospitals.

Another is the proportion of your patient mix that comes from that payer group. In particular, some groups of hospitals have a lot smaller proportion of private pay patients to obtain these subsidizing revenues from.

The other thing is how the hospital, given its mission, can adjust to differences in the conditions that they face.

DR. WILENSKY: Stuart, before you go on, at some point, and I don't mean for this year particularly, but as we move more and more to trying to think about issues in more global terms, like looking at all ambulatory as opposed to one aspect of ambulatory, do you think it would be possible to shed some light on which of the major sectors in the hospital activity might be driving some of these changes, especially to the extent that hospitals are having very different experiences? If we could know, it might be instructive as to whether the fact that some hospitals seem to be able to hold their own or to offset pressures because they're big into post-acute or inpatient/outpatient mix.

I don't know whether the data would allow you that, or whether the other demands on your time would allow that, but given the very different mix of activities that hospitals undertake and the fact that there is, not surprisingly, variation in their experiences, it might help if we could over time begin to get at that.

MR. GUTERMAN: We can do some of that. We can do cuts on it, is what we'll be able to do. It's sort of like shining a light into a room before you go into it. You'll be able to shine the light in different directions to get different impressions, but I don't think we'll ever have an overhead light in the room.

DR. WILENSKY: It may be somewhat less critical, given all the PPS movement, than it might have been before. It may be that the ability to move things around might not be quite as great, or to seek other attractive avenues of revenue.

MR. JOHNSON: While we always try and break it out into various programs, if you look at the chart we're on, which is rural hospitals, you'll find -- at least in our state -- that most of those rural hospitals get the majority of your reimbursement from Medicare, Medicaid, and uncompensated care. So when you look at the rural hospital here and, for example, you look at the impact of having all of the Medicare line of business for a rural hospital, you can see the impacts on that. And also, in terms of Medicaid and uncompensated care.

You can see where they're saying, as Tim Lee Cardy used to say, using the fat to fry the lean. He was a Congressman back in the '70s. Again, the emphasis on the private payer has an impact on that.

I get concerned sometimes when we try and break it into all of its components when there are people out there on the line trying to deliver a total product for the beneficiaries.

MR. GUTERMAN: An interesting thing about rural hospitals is that their total margins in the aggregate are greater than urbans, but they're more likely to have negative margins than urban hospitals. So the distribution is clearly much more skewed.

DR. LEWERS: Stuart, before you go off that issue, you're talking about aggregates, you're talking about averages. What about, because that's such a varied group of rural hospitals and where you're headed with it, what about those that are sole community providers, et cetera? Is there any way to break out what impact we're having on those individuals?

In other words, what's critical? I mean, there's no question, we all know some hospitals should close but we don't want to close the ones that we need to keep. That's what's worrying me, the aggregate doesn't tell me that.

DR. WILENSKY: Of course, we're not looking at access, either. We're looking at sort of the well-being in the hospital, as opposed to --

DR. LEWERS: That's sort of breaking the access point out.

MR. GUTERMAN: We certainly have the margins by category for sole communities and rural for all centers versus other rural hospitals. We have some of the data, we have data on the rural public hospitals coming up in a couple of overheads. We can certainly break that out more.

In the next overhead, we show the same information by teaching status. Now you'll notice here that rather than our traditional major teaching, other teaching, non-teaching breakout, we've broken them into teaching public and teaching private. For this purpose, it just seemed like a more appropriate breakout.

The big thing you notice here is that public teaching hospitals get treated relatively well by Medicare relative to their costs and they also have sizeable contribution to their bottom line from the private sector payers. But it's the other patient care category that everybody else is working to offset.

What this number means, and I should have mentioned it earlier, is that if public teaching hospitals were breaking even on all of their other payers, all of their other sources of revenues, they would have a negative total margin of 12.2 percent.

DR. NEWHOUSE: I don't think that's what you mean.

MR. GUTERMAN: Yes, if they had zero net revenues from all of their other payers combined, they would have a total margin of minus 12.2 percent.

DR. KEMPER: I thought the sum to the total --

MR. GUTERMAN: If the other components were zero, then the total would be --

DR. NEWHOUSE: By the share --

MR. GUTERMAN: No, these reflects the share. These numbers reflect the share of total hospital expenses that are accounted for by each payer, so this is the pure contribution to total margin by each category. So if you add these four categories up, you get the overall gain according to the AHA annual survey for that group.

DR. LONG: That would be true if these were absolute numbers, but these are percentages?

MR. GUTERMAN: Yes, but it's percentage of total hospital expenses in every case, so it's the same denominator in every case.

MR. MacBAIN: So what you've taken in each of these, the numerator is the revenue by payer, but the denominator is total expenses not -- so this is not the margin by payer?

MR. GUTERMAN: No, it's not the margin by payer.

MR. MacBAIN: This is just contribution to the hospital's overall -- the aggregation of hospital's overall margin? It's kind of a confusing number.

MR. GUTERMAN: But it allows for a more direct comparison of the contribution of each source of revenue to the bottom line of the hospital.

MR. MacBAIN: It's probably more relevant, though, to look at the direction and the size of the bars than it is to look at the numbers.

DR. LONG: So you're saying in the teaching public hospitals that if other patient care were one-fourth of the business, the margin would actually be minus 50 percent?

MR. GUTERMAN: No. What I'm saying is exactly what I said before, that if that group of hospitals were breaking even on the other groups, that the -- the total margin is the sum of the four bars. Actually, it's the total cost margin. It's the total net revenue over total costs is the sum of the four bars.

So in other words, you've got a 10.9 percent surplus for public teaching hospitals that only partially offsets the 12.2 percent loss from other patient care. That's as a proportion of total hospital expenses, so it's the same denominator in each part.

DR. WILENSKY: Why is the Medicare so small in the teaching public and teaching private, given the PPS margins?

MR. GUTERMAN: Because Medicare tends to be a smaller proportion of total expenses among public teaching hospitals.

DR. WILENSKY: Even so, in the teaching private, Medicare is like .3 where the margins are huge.

MR. GUTERMAN: The PPS inpatient margins, but the outpatient payments tend to be lower relative to costs for that group.

DR. WILENSKY: But you're talking about over 20 percent down to .3? These numbers are not intuitively obvious but maybe we can spend some more time.

MR. GUTERMAN: We can focus on where they come from but we've done that in the past. Remember, the private teaching group probably has much lower PPS margins than some of the public teaching hospitals, which are a lot of the major teaching hospitals. We can break that apart.

DR. WILENSKY: These numbers are not passing the intuitive --

MR. MacBAIN: Does the data allow you to reconstruct these on the basis of ratio of payment to cost, to go back to one of those first graphs?

MR. GUTERMAN: Yes.

MR. MacBAIN: I think that was a number that was easier to grasp, where you're dealing with what's going on within the payer category without trying to get to the actual total margin, which you were saying is a difficult number.

MR. GUTERMAN: The problem there is in the past when we've talked about payment-to-cost ratio, we felt that it's misleading because part of the problem for some of these hospitals, for instance the public major teaching group has a very high payment-to-cost ratio from private payers, extremely high. But part of the problem is that it has a very low proportion of private pay patients. So this sort of combines those two. It combines the payment-to-cost ratio and the share of patients.

Part of the issue, as you'll see in the note there, is this reflects reported data only and there's a lot of imputed data in the AHA survey. So it may be the sample of hospitals that we have, but we can take a look.

DR. WILENSKY: I'm thinking that if you think about inpatient versus outpatient, and if you think about Medicare versus non-Medicare, and then you plug into that the Medicare PPS margin, which is a very large number, I understand it will come down but it's hard for me to think about those splits that will begin to have it come to .3

or 1.6 or something. The kinds of numbers it would take to drive it down from 22 or 23 percent down to that...

DR. KEMPER: But this is just another variant of the issue we saw before of the AHA data and the Medicare inpatient data telling a different story.

MR. GUTERMAN: We've looked at analogous issues to this in the past, and we have succeeded in cross-walking the numbers. So we can do it for you. I don't have the numbers at my fingertips, but we can come back with how you get from one to the other.

MR. MacBAIN: Stuart, something that might help, too, would be to give us the formula on the data tables that generated the graphs so we can see what the numerator and the denominator are in each case.

MR. GUTERMAN: Okay. If you contrast the teaching public to the non-teaching group, you see there that although the public teaching hospitals receive a large net surplus from private payers, it's not as high as a proportion of the total resources they expend as the non-teaching group gets.

Again, that's largely because the non-teaching group has a higher proportion of private pay patients. Therefore, whatever surplus they do get from those patients comes in as a higher proportion of their total business. Of course, they have a much lower proportion of losses on other patient care.

In the next overhead you see here by ownership category. Again, you can see, if you contrast the voluntary/proprietary situations, you see that proprietary hospitals are a lot better off under Medicare largely because they control their costs more effectively than the other group.

They also have a higher share of net revenue from private payers, and that's a combination of cost constraint and a higher proportion of private pay patients in the proprietary hospitals. Again, a lower proportion of losses on other patient care and a smaller non-patient care component.

So we'll go back and we'll take a look at some of the questions you've raised, and if you have any further discussion this is the time.

MR. JOHNSON: First of all, I'd like to compliment the staff on the presentation this year. The way this was put together, looking at the total picture as well as looking at the inpatient margins. I think it gives a much fairer look at what's happening with total Medicare payments.

I think hospitals certainly, whether we're dealing with Blue Cross and private payers or Medicaid or uncompensated care, whatever it is, tend to look at the total book of business and its impact on the overall finances of the institution.

I'm certain we'll get to discuss the implications a little bit more about this after lunch today.

Stuart, another thing I was wondering also is, certainly as I look to the chart from our data book this summer on payment-to-cost ratios, it would appear that rather than just the pure Medicare margin itself or the update itself, it would appear that those hospitals that have the larger Medicare margins are probably actually getting it because of DSH or indirect teaching costs.

So as you sort of look at some of the other hospitals, I don't know what effect this has on the overall numbers, but in fact I think we tend to focus on the update factor as being the solution to any other inequity when in fact there are other kinds of factors in the formula that really drive the margins for other types of hospitals much more.

So that gets me back to concern to those outlier hospitals, those 21 percent with negative margins, those rurals that Ted talked about that are sole community providers and so on, because the update factor is the only place where the tide raises all the boats, where there are other boats that get other payments that tend to raise them up a lot more.

So maybe we can talk a little bit about that this afternoon as well.

DR. WILENSKY: I'm not sure I understand the point, though. To the extent you think there are special problems which might or might not be appropriately addressed by the mechanisms we

have in place, that would argue that you ought to look to those and not look to the general overall update, it would seem.

So if we think, for example -- and there was a statement in some of the material about uncompensated care, which we could argue about whether or not our preferred strategy would be to have it be a hospital payment, as opposed to directly going after it. But if that's where we are, we could argue it ought to be DSH, it ought to be by having hospitals that want to engage in indigent care competitively bid for the right to provide indigent care, or you could just spread money sort of generally have hospitals available.

But I think it's not obvious that you'd want to use the overall mechanism if you think it's a special problem that's driving a category of concern.

MR. JOHNSON: I'm just looking at the mechanisms we've got and I'm just saying to the point that we sort of assault the general update, that those people who don't have other sources of update, like DSH or indirect med or something else, are going to be harmed. That's all.

Jack, did you have something?

MR. ASHBY: I was just going to see if we could add one clarification to what Stuart was saying about the difference between the PPS margin being at 15 percent and the AHA data for Medicare being about 2.5 percent. I mean, it always seems like gee, that's 12 percentage points difference, that's a real big one.

But you have to remember that there are no less than six different reasons why the AHA data base gives that lower number, and each and every one of those points in the same direction, towards the lower. There are the fact that the AHA data includes non-allowable costs, that obviously lowers the margin. There's the fact that it includes outpatient, since outpatients are less than 100 cents on the dollar that obviously lowers it.

The fact that it includes hospital-based home health, they too are paid less than 100 cents on the dollar so that lowers it. The fact that they include hospital-based SNF, they too are paid less than 100 cents on the dollar. And then lastly, the fact that it includes GME where, once again, they are on average paid less than 100 cents on the dollar.

So once you add all those things up, the crosswalk does indeed explain the difference. So we ought to, perhaps, not call it a discrepancy. It's not really a measurement discrepancy. It's the fact that we simply are looking at a much smaller category of Medicare activity there. And if we did expand it to the all-encompassing category, we would explain the difference.

MR. GUTERMAN: Let me provide a hard example of that. If you start with a 25 percent margin for major teaching hospitals and then you see that major teaching hospital's Medicare share of total costs is 25 percent, that lowers that 25 percent margin to a 6 percent contribution to overall margins.

And then if you also discount then the 4 percent discrepancy between Medicare allowable costs and hospital allocated costs, that gets you to 2 percent right away.

DR. NEWHOUSE: How does that get you 2 percent?

MR. GUTERMAN: If you go from a 25 percent --

DR. NEWHOUSE: We'll talk about it.

DR. WILENSKY: Again I know this is not a this year issue, but let me put in a plug for, as we are thinking longer term, that ultimately what we need to think about, since Medicare is supposed to be concerned with providing access to care for seniors, is what it means to have some of these hospitals with negative margins insofar as it effects seniors as we can measure it.

What that would suggest having a need to look at over time is, as we've already suggested, how frequently are the same hospitals the ones that are having negative margins? How long are they having negative margins? What do we know about what it means to have negative margins, since as an observer

of not-for-profit institutions I'm sometimes astounded at how long not-for-profit institutions seem to be able to keep on ticking with negative margins.

And what, in the areas in which we seem to have these continued negative margins, it appears is going on with regard to access for the seniors, which is ultimately what we're most concerned about.

So I think this is interesting and important, but I think it is easy to focus on 21.3 percent of hospitals have a negative margin without thinking about gee, five years ago 34 percent -- or whatever the number -- had, at which point it was not obvious we were having an access problem for seniors. We now have lowered that, cut it down by 50 percent. It doesn't necessarily mean that there's even less a problem for access, depending on where the hospitals are, and what happens to them and how repeatedly they're in that category could or could not have an effect.

So at some point, again as we get perhaps in a position where some of how we are looking at the numbers becomes somewhat more routinized, in terms of the steps we have to take, thinking about how to start taking these next steps so that we really get to a point of saying so what if of knowing this information about certain hospitals over time would be helpful.

But again, it's obviously not a 1998-99 request.

MR. GUTERMAN: To the extent it will help, I'D refer the Commissioners to a study that ProPAC did on winners and losers which found generally that hospitals that were consistently losing money under PPS, what they had in common was generally managerial problems and problems in relationships between staff and management and things like that. And hospitals that were consistently winning under PPS had the opposite situations. They had prepared, they had held costs down, they had set up their provision of services in a way that would suit the system more.

DR. WILENSKY: What period was that for?

MR. GUTERMAN: I think it was looking at the early years, the mid-'80s.

DR. WILENSKY: It's the kind of thing where again, at some point this is clearly a very different world on a lot of dimensions. And trying either in-house or contracting out, especially given the enormity of changes that result from BBA, that trying to look again to see whether what was true in the early part of PPS continues to be true. Because it will be hard to say very much about, other than observing what's happening, what it means and whether it's sufficiently important to suggest that Congress intervene.

Clearly, we can count on the fact that the hospitals that are being negatively affected will stand up for themselves. But what we really need to do is see whether we can observe if it's having an impact on the seniors and what that means.

MR. MacBAIN: Stuart, do you have any information to simulate the impact of the Balanced Budget Act to extend this complete Medicare hospital margin graph through projected 1999? Or even 2000? We're really talking now about making recommendations that would have an impact on fiscal year 2000.

MR. GUTERMAN: We don't currently, because of the non-PPS part. We've done it with the PPS inpatient part and we might be able to do it with other Medicare.

MR. MacBAIN: You've got the CBO scoring on the savings, right? You've got whatever the CBO scored it for?

MR. GUTERMAN: Again, a lot of that depends on -- well, through '99 you're talking about?

MR. MacBAIN: Or 2000 if you can do it because that's really the focus of our recommendations at this point.

MR. GUTERMAN: Through '99 the only implication you can draw is that total margins are relatively stable because the data we have from the AHA panel survey shows that payments and cost

or revenues and expenses are rising at roughly the same rate, at least through '98. When you get out further, you've got to make some assumptions about those relatives which, you know, it's not just the payment side but it's the assumption you make about cost growth and that gets trickier.

MR. MacBAIN: I understand that, that's why it would have to be a simulation. But it would be helpful to try to get a sense of what the impact across entire hospitals is likely to be of the changes in outpatient and SNF reimbursement.

DR. WILENSKY: Additional comments? Thank you. It was very interesting.

Let me open up the floor to any public comments.

MS. COYLE: Good morning, Carmela Coyle with the American Hospital Association.

I want to thank Stuart and the staff for what I also believe was a very thorough and helpful analysis in taking a look at, I think, what his last couple of slides showed, which are a very complex set of calculations around the financial health of hospitals and health systems.

I also want to thank Jack. I wanted to clarify the question Peter Kemper had asked, and that is that this issue of the difference between a 15 percent inpatient Medicare margin and an overall 2 percent Medicare margin is attributable to several factors. Even from the back of the room you can see what happens on the outpatient side.

Based on calculations that you all saw, I think, at your November meeting in terms of the fact that the Medicare program for outpatient services is currently reimbursing only 82 cents on the dollar or 82 percent of costs. In 1996 it's about a negative 12 percent margin on the outpatient side.

And I think Jack has articulated, by law hospitals are also paid less than cost for home health, less than cost for SNF. All of that gets factored in when you look at the overall aggregate number, 102 percent of costs, basically, for Medicare.

I think what you also saw at your November meeting, were projections that Jim Mathews provided you suggesting that outpatient reimbursement will then drop once the new PPS system kicks into place to about 78 percent of costs. So look for that total Medicare margin to drop even further.

The second point relates to cost, and actually there are several points related to cost. Again, I think a graphic that you took a look at and was explained well, again even from the back of the room taking a look at the change in the trends in cost, both total and Medicare inpatient cost per case, we've seen significant change.

I think one of the things that Stuart mentioned was that if you take a look at payment-to-cost ratios, they are actually about 6 percent higher today than they were during the period of cost-based reimbursement.

One thing I'd like to suggest that the Commission may want to consider is how a hospital organization reacts to that kind of a situation, if you're being paid slightly more than your costs when you've got significant room to actually make improvements on the cost side versus being paid just over your costs when you've had actual cuts and declines in costs for a period of time.

This, of course, is the issue of how long can the cost cutting and cost containment efforts on the part of hospitals continue? We've seen a good period of cost containment, but I think some real questions as to how long that can go on.

That then plays into a second set of questions, and that is, I think Stuart presented some of the margins, particularly the 1998 and 1999 margins as a baseline for assessing the impact of the Balanced Budget Act. Bill MacBain, this may go to your point.

One of the critical factors in all of this is the cost assumption. When you look at projecting the impact of the BBA, and again in light of this kind of a picture or this kind of a trend, what kind of cost projections should we be assuming as we try to understand the future impact of the BBA? Is it continued cost leveling, cost declines, or will costs continue to go up?

When you take a look at the impact on margins, it will have a significant impact on those calculations, you may want to consider some sensitivity analyses, looking at for example three different cost assumptions as you proceed to take a look over time at the impact of the BBA.

Another BBA-related issue, even looking at 1998 and 1999, only about 10 percent of the impact of the BBA will actually be taking effect in those years. I think, as you probably know, most of the impact of the BBA was back loaded, kicking in really in 2000, 2001, 2002. Bill, I think it goes to your point of the importance of looking beyond the first couple of years.

We're going to be working on some projections of that, as well. As Stuart has indicated, it's extremely difficult to try to integrate the inpatient-outpatient-SNF-home health effects, but we'd be happy to share that with the Commission when we're able to do those numbers.

Finally, the whole issue of non-patient costs or the non-operating costs. In some recent work that we've been doing, it is a significant contributing factor, particularly to those hospitals in the zero to 2 percent margin range, those just above the break-even point in terms of stock market benefits, if you will, to bottom lines. I think we have to watch that very closely over the next bit of time. It was something that someone raised.

And to Gail's point, in terms of diversification strategies, another piece that we're also taking a look at and we'd be happy to share with the Commission as well when we're completed, this whole issue of what hospitals have done over the '80s and '90s in terms of diversifying their lines of care, and then understanding then the multiple impacts of BBA not only on the inpatient side but outpatient/home health/skilled nursing facilities, and again trying to track that out over the five years.

We'd very much like to thank staff and the Commission for a terrific presentation. We appreciate it.

DR. WILENSKY: Any other comments? We're adjourned until 1:15 p.m.

[Whereupon, at 12:20 p.m., the meeting was adjourned, to reconvene at 1:15 p.m. this same day.]

AFTERNOON SESSION [1:22 p.m.]

DR. WILENSKY: Jack?

MR. ASHBY: For more than a decade, MedPAC and our predecessor commission ProPAC has used a framework with eight different components in developing its annual update for PPS payments. Using the framework has given the Commission the opportunity to consider special specific factors beyond inflation that have, at times, had a significant effect on cost. Which of those factors are, indeed, playing a dominant role has changed over time.

I'd like to begin this afternoon by reviewing each one of these components briefly with a little historical prospective and a couple of points. As we do so, we'll review the ranges, the point estimates or ranges, that you specified for each of these components last year.

Before we do that, I wanted to look at this first overhead which reviews the updates that have been specified by the BBA. First you see the payment freeze in 1998, in pretty much direct response to our predecessor commission's recommendation for a zero update. For fiscal year 2000, which is the target year that we're talking about at this point, the update will be market basket minus 1.8 and the latest forecast of the market basket is 2.5.

So at this point, we believe that the actual update will be a net .7 percent. That's actually the same figure for 1999. It's good to keep in mind that beyond 2000 the next couple of updates are slightly more liberal, market basket minus 1.1. And then in 2003 it is, at the moment, set at a considerably more liberal level of market basket even.

While the update for fiscal year 2000 is already set in law, Congress would still like to know what we believe the most appropriate update would be, particularly for purposes of planning for years down the line.

As we go through the next overhead, though, let me remind everyone that these are the values or ranges that the Commission recommended last year for fiscal 1999. We'll be filling in the values for fiscal 2000 as part of our January meeting discussion. We're just getting a head start on that discussion today.

The update begins with HCFA's forecast of the market basket for next year. Then the first adjustment is for the difference between HCFA's market basket and the market basket that the Commission uses. The only difference between the two is the treatment of wages and benefits.

Ironically, HCFA chose back in the '80s to rely heavily on compensation increases in other industries because, at the time, hospital compensation increases were thought to be much too high. The Commission, on the other hand, chose to weight wages in hospital industry and all other industries equally.

Now the tables have turned, however. For several years now hospital compensation increases have been lower than the national average, and so it is MedPAC's market basket that produces the lower update in the form of the small negative adjustment that you see here for this factor.

The market basket forecast correction has been a surprisingly important factor over the years because once the update goes into effect based on a forecast it is not retroactively adjusted. HCFA's forecasts have been consistently too high. In fact, they've overshot the mark eight years in a row now, at one time by as much as 1.8 percentage points. As you see here, the correction factor last year was .4 percent.

The next three factors then deal with hospital services and input use. The scientific and technological advancement allowance provides an upward adjustment for the rates to reflect the impact of quality enhancing technologies that also raise costs. That would be things like cardiac stents and monoclonal antibodies as two recent advances.

The S&TA is what we have called a policy target or a projected impact for the target year, rather than an adjustment for past changes. It's gone as high as 1.0 in recent years and last year, as you see, we recommended a range of zero to .5 percent.

The Y2K problem presents a special S&TA consideration this year and Nancy Ray will discuss that and other technology issues with you at the January meeting.

Then the productivity improvement adjustment, it is also a policy target for the productivity gain that the Commission believes should be achievable in the target year. In recent years, the Commission has considered productivity in the general economy as somewhat of a benchmark for determining a realistic target for hospitals.

The adjustment last year, as you see, was minus .3 to minus .7. And that .7 was the five year average for productivity gains in the general economy.

Next the product change adjustment. This is intended to adjust for savings resulting from services being taken out of the inpatient stay. A little history here, back in the mid-80s, this factor was first developed in response to evidence that hospitals were shifting diagnostic tests that had been in the cost base when PPS rates were set up out to a pre-admission basis, where they would be paid for separately.

Then for a number of years there was thought to be no need for a product change adjustment and then it was revived two years ago in response to evidence that various forms of post-acute care were being substituted for the latter days of inpatient stays.

Now as we discussed last year, some of you remember, there is definitely a question of overlap between the productivity and product change adjustments and we're going to talk about that in a few minutes. But right now I'd like to hold the discussion on that until we've reviewed the framework and gone over some of our data.

The last two components have to do with case mix. When the mix of patients shifts towards higher weighted DRGs payment goes up proportionately. That happens automatically and it's perfectly appropriate, as long as the resource requirements of the patients are really going up. But when the increase in payments results solely from coding changes, we in effect take back those increases in the form of a negative coding adjustment here.

This factor, as Stuart alluded to this morning, has been critically important in past years. There have been some years where hospitals have received a greater increase in their payments through case mix increase than they did through the update. A large portion of those increases were thought to be essentially coding creep.

In recent years, we tended to think that this wave of coding change has pretty much taken its course and last year the adjustment was a small one, zero to .2 percent.

The last adjustment, generally quite small again, up to .2 percent, is an upward adjustment for increases in patient resource requirements within DRGs. This is essentially severity increases that are not captured by the DRG grouping criteria.

The framework I've presented here was originally developed a number of years ago and it's gone through some changes. It was originally developed for PPS operating payments. There have been hybrids of it for PPS capital payments and also for payments to PPS-excluded hospitals and units and ESRD facilities. When the updates for each of those payments are taken up at the January meeting, each of the respective analysts will point out to you their variation on the general theme that we've seen here. But everything essentially derives from the model that you have just seen.

Unless there are any questions on the framework itself, I'd like to present some of the results of our analysis, the factors related to productivity and product change.

First, we have a graph that tracks the trends in inpatient costs per discharge and average length of stay. These are the annual changes in these variables that we're looking at here.

If you would look first at the two black lines, these are the costs per discharge on the top and the length of stay on the bottom for all payers. You'll notice that in the late '80s the length of stay was actually nudging upwards and we had increases in cost per case at the time of up around 8 to 9 percent a year. Then by 1992 the drop in length of stay was about 2 percent, it was going down 2 percent a year, and our cost growth was down in the neighborhood of 5 percent a year.

In 1994-95, the drop in length of stay doubled to about 4 percent a year and the increase in cost per case had reached an all-time low of only .4 of a percent per year. So obviously the implication here is that the drop in length of stay has made a major contribution towards the low cost growth that we've been enjoying in recent years.

As you can see at the right-hand side of this graph, these two variables both jumped up a bit in 1996, but I have to caution you here that due to an unfortunate change in the format of the Medicare cost report there was a definite margin of error around this 1996 number. Actually, I really don't believe that it's as high as what we have shown here, but that's all the data permit us to do.

MR. JOHNSON: Do you think it's bottomed out though in terms of length of stay?

MR. ASHBY: We're going to talk about that in the next graph. That is, indeed, where we're going with this and we do want to talk about that very question. I guess I just wanted to make the point that '96 isn't the year to answer that question.

DR. MYERS: Are you also going to discuss total inpatient days? Because if you drop your length of stay but increase the frequency of hospitalization, then you may not have achieved anything. So the real issue then becomes one of the total days per thousand per year. Is that part of this?

MR. ASHBY: Right. Basically the answer to that is it's not part of this and I guess that points to the shortcoming of the fee-for-service payment system. Basically, we're talking about payment for hospital cases and so it's the trend in the cost of hospital cases that's at issue.

But the trade-off that you point out is absolutely there and I think largely the answer has to be that we deal with that in a managed care context, where you have a chance to influence the number of cases. The PPS payment system simply isn't designed to do that. We might, at some point, talk about the ways in which it might. But the way the system is set up now that is simply outside the scope of what we're dealing with.

Now if you would change from the black to the red lines here, these are the Medicare costs per case and Medicare length of stay. You'll see that in every year since 1991, the rate of increase in Medicare cost per discharge has been lower than the figure for all payers, ending up with three straight years where cost per discharge has actually dropped.

It would appear that the key reason that the Medicare cost growth has been lower is because Medicare length of stay reduction has been greater, in fact considerably greater in some years.

In 1994 and 1995, for example, Medicare length of stay fell more than 6 percent in each of those years, compared to about 4 percent for all payers. And of course, the 4 percent figure reflects the influence of Medicare.

We don't know exactly why Medicare length of stay decline has been greater but we would think that at least one of the key factors is that under Medicare hospitals have a strong incentive to discharge or transfer patients out to a post-acute provider, since their payment for the acute care stay will not be affected. This incentive is clearly much less strong, on average, for private payers where acute care stays are much more likely to be paid not on a per case basis -- which kind of relates to your point in some sense -- but on a per diem basis or a percent of charges. So that the payment is reduced when length of stay goes down.

In the next graph, we get to the point over here and that is the relationship between length of stay and cost per discharge in the next couple of years, '97 and '98. First of all, let me just point out, the reds lines here are the same Medicare numbers exactly that we saw on the previous page. All we're doing here is substituting two new variables, you might call them leading indicators if you will. These are variables that are available to us from the American Hospital Association on a much more timely basis than the cost report data from HCFA.

The measure and the sample and the time period, they're all a little different, but they still are at least useful for gauging the general direction of our Medicare variables, if not the exact points.

DR. WILENSKY: Jack, there was some reference in the appendix about this was a very small sample or a small sample? How problematic is that?

MR. ASHBY: You mean on the leading indicator numbers, if you will? Right, the black numbers here are from the AHA panel survey and it is a sample of hospitals, approximately 1,800 hospitals

I believe, maybe one-third of the total. As we also saw in this morning's presentation that Stu made, the fact that this is a sample does indeed affect the results. The trend in the universe numbers don't necessarily follow the sample, which is to say evidently the sample is not quite as representative as it might be.

DR. WILENSKY: That's a big number.

MR. ASHBY: Exactly. But in this case we don't want to jump to the conclusion that the difference between our Medicare lines and the AHA numbers is due to that difference in sample. That's probably not the case. Primarily the difference in values that we see here is due to the fact that the black line is an all payers' number and that's kind of the point of our previous graph because the length of stay reduction has not been as great for other payers. So you result in higher figures.

If you go back to '89 and '90 it was exactly the same. So that's the primary point of this, but not to take away from the fact that the sample doesn't necessarily do a perfect job of representing the industry by any means.

DR. CURRERI: Jack, why does the length of stay in this graph show that the percent change for Medicare is above that of the total population and on the previous graph it was much below?

MR. ASHBY: No, I don't think it says that. Actually, we've got to review here.

DR. NEWHOUSE: One is 65-plus and one is --

MR. ASHBY: Right, on this graph the two red lines are the length of stay change. So you can see that the PPS change is a much bigger drop in length of stay in every single one of the years. So that's the first thing.

Now when we move to the next graph, we've changed the situation a little bit, as Joe is pointing out. The best leading indicator we could find for suggesting where the PPS length of stay will go in the next couple of years is the length of stay for the 65-plus population. That's the black line at the bottom.

It's not much different than the Medicare length of stay but it is. There are some elderly people that are not eligible for Medicare and, of course, there are some non-elderly that do show up in the Medicare numbers. So it's not exact but it should run parallel and generally it does.

Did I answer your question?

DR. CURRERI: You answered my question. I'm not sure I understood it.

DR. NEWHOUSE: One is everybody and one is 65-plus.

DR. CURRERI: I understand that. But the 65-plus should approximate the Medicare population.

DR. NEWHOUSE: It does.

MR. ASHBY: It does. And that's what you see on this graph.

DR. CURRERI: I misunderstood. I misunderstood. Okay, I understand now.

MR. ASHBY: The trick is, we switched measures on you going from one graph to the next. I'm sorry about the confusion there.

As you can see, looking at these '97 and '98 points, the change in cost per discharge has moved to a new, even lower level for these two years. In fact, it's the lowest ever recorded in the AHA database. But at the same time, the drop in length of stay is smaller and that's the real point of this graph.

It suggests that cost influencing factors other than length of stay now seem to be driving the reduced cost growth. Recent BLS and AHA data suggest that two of the important factors that are taking over are lower compensation increases and improved labor productivity.

The hospital compensation increases in '97 were literally half that of all industries, 1.5 versus 3.0. When you think about it, in times of low inflation that's a huge difference. AHA's labor productivity measure registered the largest gain in '97 that had ever been recorded and year-to-date '98 looks even better, actually.

Next we see the results of a model that we developed with the primary goal of estimating the net impact of length of stay reductions on hospital costs. When length of stay is cut there is inevitably an increase in the intensity of services provided per day as the cost of some services, and particularly surgery is spread over fewer days.

So the concept here is that if we separately measure the change in length of stay and the change in intensity of services per day, we can simply net the two change numbers against each other to produce a rough estimate of the overall product change.

Now the left-most term here is real or inflation adjusted costs per discharge with, in this case, the discharges adjusted for real changes in case mix. Of course, when you use the word real with case mix, we're referring to non-upcoding changes.

This is essentially a measure of the overall productivity of hospitals in producing discharges. And the change in the figure is a function of changes in the other three components, length of stay, intensity of services per day, and the real cost of producing services.

By the way, services in this context is referring to virtually everything the hospital charges. That would be things like lab and therapy, surgery, drugs by all means, room and board, the whole spectrum.

Now if you'd concentrate for a moment on this left-most column, you see that the real cost per discharge was increasing at the rate of 2.5 percent a year in the late 1980s, but that that annual change has moved all the way down to minus 2.7 percent over the last three years.

Then focusing on the bottom row, for the most recent period, we net the length of stay and the intensity changes -- that's the minus 3.3 and the plus .9 -- to arrive at our estimate of product change, as we see on the next overhead.

And there is the bottom line, product change averaged 2.4 percent a year during this period and was responsible for almost 90 percent of the real decline in costs per discharge with improved efficiency in the production of services responsible for the rest.

I'm asked frequently why, when we've had such low cost growth, is the productivity improvement in turning out these services so small. I think the answer to that, in a nutshell, is that the overall quantity of services that the hospital industry is producing has gone way down. It is, in an absolute sense, considerably lower today than it was five years ago. Basically Econ 101 sort of tells you that it's very hard to improve your productivity when the volume of services you're trying to turn out is going down.

Now the leading indicators, if you will, that we looked at in the last graph suggest that when the data become available we'll find that the real inputs per discharge fell even more in '97 and '97, at least minus 3.0, perhaps as high as minus 3.5. And also that the next product change term that you see here will be a much smaller share of that overall total.

MR. MacBAIN: Just back up a second for a point of clarification on this. When you're talking about per discharge, is this PPS admissions or is it adjusted discharges or adjusted admissions?

MR. ASHBY: No, this is strictly inpatient.

MR. MacBAIN: So it's straight discharge?

MR. ASHBY: Right.

MR. MacBAIN: So when you're talking about reduction in the services, you're really talking about a reduction of inpatient services, not overall?

MR. ASHBY: Exactly. And when we were comparing to all payers, by the way, that was strictly the inpatient, as well. We had to go to some length to get that measure so it would really be comparable.

MR. MacBAIN: So one of those was adjusted admissions?

MR. ASHBY: Right, the leading indicator one is the adjusted admissions one because that's all we have for '97 and '98, so it's just the best thing we had to look at.

DR. KEMPER: To relate this back to the update framework, the real change in input use per service unit is the productivity improvement?

MR. ASHBY: I think the way to look at it is that the real change in input use per discharge combines the effects of what we call our productivity adjustment and our product change adjustment.

DR. KEMPER: And the allowance for scientific and technical advances, because that's in here too, right?

MR. ASHBY: Yes, I guess that's right. When you provide extra money to pay for those new technologies, it will inevitably show up as lower productivity the next time around because that's the nature of the measure.

DR. KEMPER: Or it's the actual revenue, the actual change in scientific and technological.

MR. ASHBY: Exactly.

DR. KEMPER: So it's all three of those combined.

MR. ASHBY: It captures the effect of all three of those combined, right. At this point, we can turn to the issues involved in setting our productivity and product change adjustments.

The issue that the Commission has struggled with the most the last two years is the overlap between the productivity improvement and product changes. As Peter pointed out, there's overlap with the S&TA as well, but somehow that doesn't cause as much trouble. It's easier to see that we're providing extra money to pay for those technologies.

But both the productivity and the product change adjustments are negative and so the question is what is it that we are adjusting for with each of these two adjustments? And if they do overlap, and you set each adjustment separately, then you do have a potential for adjusting more than once for the same change. That, indeed, would be a problem.

We represent this in a simplified way with this Venn diagram here. There are three possibilities in this upper part of the current scenario, and I thought it might be useful to give an example of each one. The exclusively productivity improvement would be something like purchasing new floor polishing machines or new machines in the dietary department or something that allow a few staff positions to be cut. Presumably that kind of change does not affect the content of our discharges and hopefully not the quality either, but it does cut the cost of producing them, solely productivity improvement.

The best example of the overlap situation is something like endoscopic surgery. When patients can go home after five days with the same level of functioning that they used to be able to reach after seven days, that's definitely a more productive way to accomplish the surgical episode. It would be hard to argue that point. But it's also a product change in the sense that the whole array of services that went into those last two days, from nursing care to food and what have you are no longer part of the inpatient stay.

Then over on the right side, the example of exclusively product change is part of the costs involved when we substitute some form of post-acute care for the last day or two of a PPS stay. In the paper I use the example of a SNF day that cost $500 being substituted for an acute care stay that costs $800. That's a net $300 savings to the system and clearly that is a productivity improvement, at least it's a productivity improvement for the overall health care system. And we believe it's right that that does count towards the productivity adjustment.

But the remaining $500 is a straight dollar-for-dollar shift from one setting to the next. And given that none of the dollars have disappeared, we can in no way call that a productivity improvement.

Now the need to adjust for that kind of a shift obviously arises out of the fact that Medicare picks up a new payment obligation for the $500 SNF service and, at least under current policy, there's no change at all in the payment for the acute stay.

Ideally, there needs to be a payment shift to go along with the cost shift. It's not in any way to label this as an inappropriate shift, just to say that when we shift costs we really ought to be shifting payments along with them, so that Medicare is getting what it's paying for in each one of these settings.

Since it was this issue, this shifting issue, that prompted ProPAC to bring the product change adjustment back into the update in the first place, we wanted to propose at this point that the scope of the adjustment be narrowed to cover only the dollar-for-dollar shift.

All other product change is the result of net reduction in the inputs required to meet the patient's needs regardless of where in the system it occurs. Any net reduction in inputs would be included within the scope of the productivity adjustment. And that creates the bottom scenario in our Venn diagram here.

I think that part of the advantage of this is not only that it eliminates conceptually the overlap between the two, but it then creates a productivity adjustment that is more closely aligned to the productivity data for the general economy that we use as a benchmark.

Now while the approach more cleanly differentiates the two adjustments, as we say, and it also targets the product change adjustment in a more focused way on the issue it was intended to address, the problem is that we have no way to directly measure this limited form of product change. We can't really isolate the dollar-for-dollar shift quantitatively.

Using results of our model that we just looked at, we estimate that there has been a cumulative product change of about 13 percentage points covering the period from 1992 to 1998. And then remembering that four points of that can be considered to essentially have already been covered by the Commission's last two update recommendations, there is a remainder of 9 percentage points.

Now if we saw the adjustment as a complete adjustment for all product change, then 9 percent would be our estimate of the number. It would be as simple as that. But with the more narrow definition of product change, the site of care substitution that we are trying to target, the correct number is obviously something smaller than 9 percent.

We can't target it specifically but at least we have put a band around it. It's something more than zero, I'd suggest something significantly more than zero, and it's something less than nine, and again not marginally less than nine necessarily. It is somewhere in the middle of those two numbers.

The plain truth is that the evidence of the shift of cost is compelling on the one hand but the evidence is entirely direct. We just kind of review it in this next overhead. Basically there are four forums of evidence, if you will, that we have brought out in past analyses of this site of care substitution.

The first one is the one that we've been talking about here, the fact that Medicare's length of stay reduction is much greater than that of the other payers linked to our incentives issue.

The second one is that Medicare's volume of post-acute care did indeed go up dramatically during the same period that hospital length of stay was declining. We're not just talking about the overall volume but the volume of post-acute episodes that began immediately after a hospital case went up dramatically as length of stay was declining.

Thirdly, we know that the drop in length of stay has been the greatest in the DRGs where the use of post-acute care is the greatest.

And lastly, we know that the decline in length of stay has been greater in hospitals that actually operate their own post-acute services than those that don't. So all of these provide some evidence of the phenomenon but none of them measure it exactly.

Along with narrowing the scope of the product change adjustment, we would like to rename it the site of care substitution, just simply so it describes this narrower focus that we're trying to

capture. Because we wouldn't have the intention of adjusting for all forms of product change it's probably best not to use the term product change for the adjustment.

While we're on the topic of names, the idea of changing the name of the productivity adjustment has also come up a couple of times in Commission meeting discussion. The issue here is essentially this: at the conceptual level, productivity growth results from a reduction in the inputs required to produce a constant output. But in fact, hospital output is anything but constant, either in content of our discharges or in the quality of care. And so perhaps another label, possibly something like an input use adjustment, might be more accurate.

But on the other hand, we tend to fear that the name change here might cause some confusion, whether technically correct or not we at least have a term, a concept that everybody's familiar with. We might also argue that, in fact, we are attempting to adjust for productivity change in the true sense of the word, even if we don't have the ability to measure it. We don't have the ability to measure a number of these things very well.

So those are two things for your consideration, name change wise and an issue of narrowing the scope of the adjustment.

Just for a moment, the last thing I wanted to go over is a couple of considerations in actually setting the adjustments even though we're going to hold the decision on the amount of these factors until our next meeting when we'll have information on the table for all of the components.

On the productivity adjustment first, as I said before we have frequently used the productivity performance of the general economy as a benchmark. In this table we see what that performance has been. These are what they call total factor productivity results, that is they combine labor and capital. But since that measure is only available through 1966 -- I'm sorry, 1996 -- that would be the ultimate in government data --

[Laughter.]

MR. ASHBY: -- we use the trend in labor productivity, which is much higher by the way than this number, to estimate the figures for '97 and '98.

The 1.4 percent figure that you see here is historically quite high. You have to go back a couple of decades to find performance at that level. And yet, the data that we have been reviewing today suggests that hospitals has exceeded that level in both '97 and '98. So that raises the question of whether we want to tie the recommendations specifically to what's happening in the general economy if you believe that hospitals are capable of a greater performance.

At the same time, we have to remember that the productivity adjustment is essentially a forecast of what the industry can do in the year 2000. As the stock market people would say, past results are not indicative of future performance, and we have to keep that in mind as we look at the year 2000.

Then on the site of care substitution adjustment, the level can indeed, as we've been implying here, reflect your estimate of the cumulative impact of site substitution. As we mentioned before we think the number is somewhere between zero and nine. If the appropriate level, in your judgment, is too great for a single year it can indeed be phased in over more than one year.

Then there's one other consideration that we think really ought to be kept in mind when we quantify this factor, and that is the transfer policy that was mandated by the BBA. That went into effect on October 1 of this year and HCFA estimated that this policy will cut payments by .6 percent. You can sort of view that as that's exactly the same as a minus .6 in our update framework. So that's just something that should be kept in mind when we set this level.

So that's it. Any questions, first of all?

DR. LONG: If I could with the indulgence of my fellow commissioners, take a few minutes to go back to first principles, this being triggered by the hypothetical that you had on page seven about the substitution of the SNF day for the inpatient day.

My recollection of a year ago was that when people from the two predecessor commissions, plus some new people, got together there was some significant divergence of where we were coming from on some of these questions. I'm not sure we reached consensus. At least that's my recollection, but we sort of agreed to go along with sort of the middle of the road where we were because it really didn't make any difference since it was really set in statute and we weren't making an operative recommendation.

But for my edification, I'd sort of like to know where my colleagues are and trigger off some of those similar notions that you had in your paper, Jack. You cited some other things today and what I'd like to see is where we are on these things relative to at least the methodology of prospective payment from the inception which was gee, if hospitals could do it more efficiently they got to keep the savings.

If you talk about something like just pure efficiency or productivity gain, supposing management comes along and figures out how to change the scheduling of all the things that take place within an inpatient episode, such that you're using exactly the same technology, you're just doing it in a shorter horizon and you can discharge the patient one day sooner in exactly the same status as before, you've just been able to compress things better. This will save a little bit of variable cost on that length of stay day that you no longer have.

MR. ASHBY: If you cut the day it will save considerably.

DR. LONG: Save the incremental costs, but you compress some of the things that would have happened on the last day into an earlier part of the length of stay. Do we all agree that that's something that the hospital should capture 100 percent of the benefit of? Supposing you shorten that length of stay and you save $300. Is it our concept that that $300, that no change is made in the episode payment, the DRG payment, and the hospital wins and keeps all that savings.

Do we agree with that? Is that consistent with where we are?

DR. NEWHOUSE: I thought the idea was that the hospital would keep it initially, but the government would adjust to the average over time.

DR. LONG: That's my question, is there a recapture? Is there a sharing?

DR. NEWHOUSE: There would ultimately be capture but it wouldn't be at the individual hospital level.

MR. ASHBY: Indeed, that is exactly within the scope of the productivity adjustment. The Medicare program is, in essence, taking back the savings from that the following year. We're not necessarily taking back all of it because we have a several year track record of setting productivity adjustments that are much smaller than the productivity improvements that were actually achieved.

But be that as it may, that's what the adjustment does.

DR. LONG: Is what we're taking back the national average, and if that savings was greater than the national average then the hospital gets to keep it? Are we taking back 100 percent of the savings? What is our philosophical position here, leaving aside any questions of forecast versus actual? Where are we on that?

MR. ASHBY: I think we're taking back on average definitely. The very nature of the prospective payment system is that if the provider can beat the average they do indeed profit from it.

DR. NEWHOUSE: That emulates the competitive industry work. You can beat the competitive market price you get 100 percent of the savings. But if everybody figures out a way to do that, the price will drop.

DR. LONG: Now is that any different than your capital substituting for labor example, where we get the fancier floor polishers and that means we don't have to hire as many people?

MR. ASHBY: I think it's exactly the same.

DR. LONG: Is that any different from just the pure rearrangement of the resources?

MR. ASHBY: As far as I'm concerned it's exactly the same because we want this to capture both labor and capital, operating and capital payments, if you will.

DR. LONG: Now when we change the nature of the inputs in a technological sense, we now have with new knowledge or new technology, the ability, the endoscopic surgery example or whatever, to produce the same outcome in a shorter period of time. Then where are we philosophically? Are we saying if that new technology is more expensive we're going to pay you for the new technology and then take away the savings for productivity?

MR. ASHBY: I think what we're suggesting with the narrower scope of the product change adjustment here is essentially that in pure dollar terms that kind of example is also the same as the floor polishing machine example. Either way you are producing the same end point with fewer resources, that is a productivity adjustment, that is what we intend to adjust for with the productivity adjustment.

The difference that we have to keep in the back of our minds, of course, is that presumably the floor polisher adjustment has no impact on quality. The patient should not even be aware that all this is happening. The patterns of care examples do have the potential to impact on the quality.

DR. LONG: But aren't we kicking something in for S&T?

MR. ASHBY: For the sake of argument, we say all right, the patient's reaching the same level of functioning at the end of that stay that they did before, quality has not been affected. It is a productivity improvement, the same as the floor polisher one and within the scope of our adjustment.

DR. LONG: Now are we paying for the higher cost of that new knowledge, new technology with S&T?

MR. ASHBY: By and large, no. The distinction that we make on the S&T is that when we set that level we are providing additional monies for technologies that don't improve productivity of care, but there is a quality reason for having them. For example, when we added MRI to our array of scanning abilities, that added useful clinical information to the physician but presumably it didn't cut length of stay, it didn't produce savings, and not only that you had to pay for the machine and all the staffing that went with it.

We felt that there were enough quality reasons to justify spending Medicare funds for that and we wanted to make sure that it was covered by the update. That's the purpose of the S&TA.

DR. LONG: So if it's a new technology that improves quality without --

MR. ASHBY: And increases costs.

DR. LONG: And increases cost without any attendant savings, then we put in a kicker for it?

MR. ASHBY: Right.

DR. WILENSKY: Because you're trying to capture the savings the other way around, is that what you're asking?

DR. LONG: Yes.

DR. WILENSKY: You don't try to capture the savings of a new technology that reduces costs.

MR. ASHBY: No, we have always said that new technologies that reduce costs are captured by the productivity adjustment. Certainly, many of the ways that you improve your productivity have to do with introducing new technologies that are lower cost. I mean, even the floor polisher example fits into that category. You still have to pay for them but it cuts your costs over time. The same would be the case with many other technologies.

MR. GUTERMAN: There was debate over the years about what the meaning of the scientific and technological advances allowance was, and the latest version of it was that the purpose was to allow for cost increasing quality increasing technology, and therefore the net cost increase. And it would

be a net cost increase, that part of the analysis would involve when we used to do more detailed analysis of that issue, the cost increase would be the net cost increase.

If there was an increase say in acquiring the technology and applying the technology, but that technology once applied would decrease the cost of providing care in that year, in the coming year, then that decrease was partially netted out of the S&TA.

Now in future years, once that was no longer a new technology that was covered under our S&TA conditions, that would be part of the productivity. But there was a continuing discussion about whether cost decreasing technology would be included as part of the S&TA as an offset or part of the productivity target.

DR. LONG: Generally I'm comfortable with that framework, but what I'm mostly interested in is where everybody else is.

DR. WILENSKY: Okay, we'll let people have a chance to say, as they make comments.

DR. NEWHOUSE: First, Jack, let me thank you for a clear -- I think as clear a presentation of pretty difficult material as you could have gotten.

Where I come out is, however, that at the end of the day there's just a lot of judgment involved and the numbers cannot take us all that far. Let me focus on the productivity adjustment and several concerns with it.

First, are a couple of points on the relationship between what we put in and the number you have for the rest of the economy. First of all, just so people who aren't economists understand this, the productivity measure is a measure of the change in total value of goods and services divided by a change in the price index. So it's an attempt to measure the change in the quantity of real goods and services that comes from year to year since the total value of goods and services is the price index approximately, the change in that plus the changes in economy.

So since we can't measure the change in real goods and services across the economy, we approximate that as the residual from netting out the increase in GDP minus the increase in the price index.

Now that means that any problem with the price index straightforwardly translates into a problem with productivity because one is just the mirror image of the other.

There's a big debate in the country about the possible bias in price indices. For the Consumer Price Index the Boskin Commission thought that that could be biased up by a full percentage point. BLS thinks it's, if I recall correctly, more like a half a percentage point.

But the point is there that these numbers, half a point, a point, are very large compared to these numbers on your last slide. So that another way to say this is that --

MR. ASHBY: Wait, the national number is much larger than --

DR. NEWHOUSE: No, the possible bias in the productivity measure is a large number compared to what you're showing as the change in productivity. You're showing changes on the order of a half a percent and then, in the last few years, a percent-and-a-half. But if there's a half a point to a percentage point bias, then that's a big bias compared to these numbers.

The BLS actually, on the Consumer Price Index -- I'm not sure what price index you were using to get the labor productivity, GDP or the Consumer Price Index. But either the GDP or the CPI revised its procedures in the last couple of years.

MR. ASHBY: This reflects the new --

DR. NEWHOUSE: -- and that added 4/10ths of a point to the productivity change. So part of this is just a revision of the price index that underlines that part of this change is presumably a statistical artifact rather than a real change.

MR. ASHBY: I compared the old and the new series before we came up with these --

DR. NEWHOUSE: No, this is the underlying price index series.

MR. ASHBY: That's what I mean. Before we came up with the 1.4, the numbers in the last one we compared.

DR. NEWHOUSE: Let me go on. The second point is, I'm not sure how much we should be influenced by whatever the change is in rest of the economy for the productivity change in the hospitals. If you think about, for example, what computers are doing to productivity in the general economy, they're doing something.

Within the health industry, probably they've had a huge impact on productivity in labs and not much impact on productivity in home health. So indeed, it's not clear to me what you would do about productivity in home health.

So the fact that stuff is going on in the rest of the economy may or may not apply very well to hospitals or health care. It may, it may not, it's kind of a judgment call.

The third thing looks on the surface like a semantic issue but I think it's actually much more than that, which is the discussion you get into about should we call this productivity? I would actually like to call it through-put I think that's what you're actually measuring. It's kind of a measure, conceptually at least, for a given amount of resources how many admissions or discharges do I get out of those resources? Which is sort of like saying how many seat miles did I get on my airplane.

The reason I think it's more than semantic, that is more than what you call it, is that in principle I can get more through-put if I cut down the staffing. That is, I get more seat miles per unit of input out of coach than out of first class on an airplane because I have fewer flight attendants per seat, among other things.

But the problem with calling that a measure of productivity is that you'd like to met out the value of the change in the product. That is, if you have fewer nurses for the same number of discharges and so patients feel that service has somehow deteriorated and nurses get there less quickly when they summon them to the bedside, the value of that in a true productivity measure has to be netted out. But this measure doesn't make any attempt to do that and that's reasonable. I mean, I don't know how you could do that.

That's why I don't like to call it productivity. It's really not productivity, it's through-put. That's why I get back to my point about we have to make a judgment because ultimately, for example, what we say hospital rates should be increased by will affect decisions on staffing and will affect compensation decisions, as you've said, which will in turn feed on presumably what kind of person is choosing to go into this labor market.

That's all a factor in what one wants to pay. I mean, what do we think staffing levels should be? That's a judgment.

The final thing is this exchange you had with Hugh about new products and S&TA and so forth. The only point I was going to make there is it's hard to make a clean separation of that because some of the S&TA or the new product lines, if you will, are going to feed back into these measures you've got.

In fact, that's your endoscopic surgery or think of say, antibiotic treatment of ulcers. I drastically changed, if you will, through-put measure by changing the treatment and that's, as you say, for the cost increasing but benefit increasing measures that we were putting the S&T in there for, that's also going to affect the through-put.

So I guess I have two things. Just like Ted likes to be humored by calling it professional liability, I would rather call it something other than productivity. But I think that that embodies a real set of issues that the numbers can only take us so far in trying to decide what this update should be.

DR. WILENSKY: I'm not sure I understand where you ended up in your recommendation.

[Laughter.]

DR. NEWHOUSE: My recommendation is that --

DR. WILENSKY: I understood the last point. The middle point, in terms of what to do --

DR. NEWHOUSE: What to do with what?

MR. ASHBY: Relative to the national number?

DR. WILENSKY: Right.

DR. NEWHOUSE: I don't mind trying to have the national number in front of us, but I just don't think that it should affect us that much. In fact, if anything, I think we just have to make a judgment about what we think -- how much hospitals can increase through-put for a given amount of resources or alternatively for a given amount of discharges reduce the resources. We call that the productivity hurdle you have to jump over, which I think is kind of how it started out.

It may or not bear how much Ford is using in terms of inputs to make a car and how much that changes from year to year. That may not be very helpful in trying to decide what should go on in hospitals.

DR. WILENSKY: It's really an expectation of --

DR. CURRERI: But it's not just through-put, it's through-put while maintaining quality.

DR. NEWHOUSE: That's productivity. But that's not what we're measuring. We don't really make any pretense to measure that.

DR. CURRERI: But it comes into your judgment, doesn't it?

DR. NEWHOUSE: Yes, absolutely.

DR. CURRERI: Because you could reduce the nurses down to one nurse for the hospital but that wouldn't obviously fly.

DR. NEWHOUSE: That's my point

MR. MacBAIN: I have a handful of things. First, of all, the terminology if we're all going to weigh in. Site of care substitution is find with me, as long as we don't have to call it SOCs.

[Laughter.]

MR. MacBAIN: Being a non-economist, I'm comfortable with the productivity adjustment, if for no other reason than to maintain some consistency somewhere in this process with earlier reports. But I think in lay terms, at any rate, it has meaning although I certainly would acknowledge the issue that the product itself, even more than automobiles, changes a lot year to year.

I'm assuming that in that productivity adjustment, if I understood what you said earlier, that in the case of a site of care adjustment any net that fell out of that would be then deemed a productivity adjustment. So if we substitute a $500 SNF day for $1,000 hospital day, the $500 net would be productivity savings.

MR. ASHBY: As you see in the model, it will show up in the product change column but then the product change column and the service productivity sum up to the total. So it's, by all means, reflected in the total.

MR. MacBAIN: So it shows up -- because there really is, in a sense, a productivity change there in the sense that you're doing the same thing but you're doing it in a less expensive setting. The net effect of that, if you're interested in measuring productivity separately, would be -- in my mind at least -- a productivity change.

I tend to agree with Joe that looking at the national productivity figures is not real helpful because in hospitals when you add capital more likely than not you're going to add labor rather than replace labor.

And back to Hugh's point of what our philosophical approach in all this is, which I think is worth trying to nail down. My approach is that with administered prices, we're trying to simulate what would happen if there were ca competitive market, which would mean that if a producer finds a more

efficient way of producing a product, initially the savings go to the producer. But over time, as competitors discover the same secret, the savings eventually for the most part go to the purchasers.

And similarly, if a producer learns to make a better product and therefore can sell it at a higher price, even if that means incurring higher costs as well, then the higher price you'll obtain and any profit resulting from that will obtain, but only until the competitors can also produce a higher quality product.

I think that's what we're doing with our technology adjustment, in effect, is saying that yes if you're producing a better product at a higher net cost, we'll recognize that since there isn't a way for you as a producer to set your price and test it in a market. We're just going to have to make some gross estimates but try to factor that in.

So we're simulating both on the upside and the downside what would happen to pricing in a competitive market.

Finally, a question for Joe, and that's on the CPI bias. Is that bias also present in the market basket? And if so, are we simply offsetting a market basket bias in one direction with the same bias in the productivity adjustment?

DR. NEWHOUSE: The bias comes from a whole lot of different factors. I don't consider myself an expert in this area, but my guess is that many of those factors apply less to the market basket. Although, one of the sources of bias is the frequency of updating the market basket in the CPI, which is only done roughly every decade. In fact, the new market basket is introduced five years usually after the survey.

So worst case, you're 15 years out of date with the market basket.

MR. MacBAIN: But I'm talking here about the hospital market basket that we're adjusting.

DR. NEWHOUSE: What I'm not clear is how frequently the hospital market basket is updated. Every five years, Stuart tells me.

MR. MacBAIN: Is the CPI one of the components of that? It's a subset of that, which would the hospital wage index.

DR. NEWHOUSE: No, it's a factor price index.

DR. KEMPER: I agree with Hugh and Bill on the principles. I guess I just want to come back to the relationship between the framework and your analysis of variables related to productivity.

If I understand it right, the middle three items in the framework, the scientific and technological advances, the productivity improvement, and the product change, all three of those are really encompassed in the real input use per discharge; is that correct?

MR. ASHBY: Right, the impact of them post high.

DR. KEMPER: Yes, the historical impact of them, all three of those are incorporated?

MR. ASHBY: Right, is captured by that term, right.

DR. KEMPER: And that the scientific and technological advances and the productivity improvement are really, in your third term, the real input use per service unit?

MR. ASHBY: That is true, yes.

DR. KEMPER: Those are in there. So I guess my question is -- and it really goes back to whether or not the data, how much they tell us in terms of the actual making the update recommendation. It seems to me they tell us an awful lot because you've presented the historical evidence on those components. I mean, you've combined two of them into one and however we label it that's one piece of it.

And we could take out the site of care substitution out of the adjustment. So it seems to me the historical data tell us a great deal.

If we said, following the principle that in a market what would happen if there were a reduction in costs or an increase, for example, for that matter with a lag of a year or some period the market would adjust to that new price. If we use the historical data, that would allow us to make the judgment, say we'll make that update with a lag, much as if the market would.

That takes us out of trying to guess what scientific and technological advance should be. It grounds us more in historical data. And I certainly agree that the productivity of the general economy shouldn't necessarily bear a relationship to that in health care. It could be higher or lower. The general economy is driven by the business cycle importantly.

MR. GUTERMAN: Just on that point. Let's not get derailed by this issue of general productivity and general economy. That really came about because in the early years of PPS we saw real declines in hospital through-put. We were going to call it malpractice but...

[Laughter.]

DR. LEWERS: That might be the right place for that word.

[Laughter.]

MR. GUTERMAN: ProPAC had to then deal with the notion of how to set a productivity target for an industry that had declining productivity but that there was the feeling that productivity should still be expected to increase from the point of view of the program. So lacking a better sense of what should be going on, we used the economy-wide numbers as a benchmark.

But this is a different world here so it's entirely consistent to say well, we ought to expect hospitals to improve their productivity by an amount that is more specifically appropriate for the hospital industry.

DR. KEMPER: I guess I'd like to get some reaction to the notion this new accounting identity is really helpful in setting the rate, the historical data.

DR. NEWHOUSE: I think it's potentially somewhat helpful, but what it misses and can't really do, doesn't pretend to do it, is any real adjustment for quality change. So as I say, if I have lots of harried nurses running around the hospital now and they weren't that way before, and patients would be willing to pay for less harried nurses, then that isn't in here.

The other thing, I wrote down must do S&TA in response to something you said, which I can't remember. But I think the idea is that as new products come along, new products are always big trouble for price indices and for productivity measurement. I mean, there's conceptually a way you could tell students to handle them but in practice can't be implemented. So the statistical agency struggled with them and we struggled with them. We have to do it. It's there.

I was going to raise a different issue, though, that Jack raised that we really haven't, I think, talked about yet. I'll call it the recapture issue for the site of service changes in the past. Jack has presented us numbers and I don't really quarrel with his numbers, that there could be -- if we'd been adjusting as we went along for the substitution post-acute, we would now be paying 9 percent, plus or minus.

MR. ASHBY: Remember, we were saying that that 9 percent captures more than just the site of care substitution. So it's something less than 9 percent, it's maybe 5, 6. But even 5 and 6 is not a trivial number.

DR. NEWHOUSE: Whatever it is, there's a policy issue about how we want to treat this going forward. I mean, there's an issue, of course, about what it is but on the assumption that it's more than a trivial number, and I would call five or six more than a trivial number, should that in some sense factor into our future update, views of future updates?

I guess I have mixed feelings about that, kind of a sense that that was then and this is now. I guess the issue is are we -- again, I guess it's a judgment call, are we overpaying? Stuart presented a lot of data on that point.

Maybe we should talk about that for a minute. That is to say even accepting that the rates would be lower by some non-trivial amount had we adjusted in the past for this, do we want to lower them now?

DR. WILENSKY: In the past or in the future?

DR. NEWHOUSE: In the future.

DR. WILENSKY: But not based on what's happened in the past but what we can measure?

DR. NEWHOUSE: Yes, in effect this would be like an error correction.

MR. ASHBY: The proposal, as it stands now, does amount to adjusting for the future to take into account the impact of things that have happened in the past, and it is somewhat like a correction factor.

DR. NEWHOUSE: So that's the issue.

MR. ASHBY: But let me just add the other side of the coin. We don't and we never have, and haven't proposed to do the same for the productivity adjustment. If you go back and look at the productivity adjustments made three and four years ago by our predecessor commission, it's clear as a bell that they undershot the mark on the productivity improvement that could be achieved by the industry. I mean they went way over the --

DR. NEWHOUSE: Again, they overshot it on the through-put. It's not clear --

MR. ASHBY: I'm sorry, on the through-put, yes.

DR. NEWHOUSE: It's important because there's no quality adjustment. The through-put adjustment is overstated.

MR. ASHBY: I didn't mean to pick on that point, though, but I mean they did undershoot the mark in terms of the --

DR. NEWHOUSE: You can't say that, Jack. They overshot it if there was no change in quality that anybody was willing to pay for. Then they overshot it. If there was a change in quality, then you don't know.

MR. SHEA: The point that Joe is making is an important one and going back to one of your earlier comments, Joe, the amount of judgment that's involved here is substantial and this is where the judgment, I think, kind of pushes the limit.

Although I kept on thinking, throughout this discussion, that maybe there's another notion we should get in here which is are those harried nurses and more efficient floor polishers getting a raise? Because if they were getting a raise, then I'd be for giving them money. But I have this feeling they haven't been getting the benefit of this productivity.

DR. MYERS: I love it when economists get excited.

[Laughter.]

MR. SHEA: It's an end-of-the-year phenomenon.

[Laughter.]

DR. MYERS: Are there specific data elements prospectively that we could collect that would allow us to render a better judgment of whether there has been overpayment? I'm trying to get back, Joe, to your point.

We have made these decisions based upon indices that may or may not reflect what actually is happening within the health care environment. Okay, I accept that.

So if we believe that what should we look for going into forward years that would give us a better sense of whether we've done the right thing? Are there things that we could do?

DR. NEWHOUSE: I don't have any quick answer to that. I think that is the right question but it's very difficult.

DR. MYERS: Is there a process that we could suggest? Is there a way for us to become better informed on what those options would be? Because Medicare's not going to go away. If we think this is an issue --

DR. NEWHOUSE: I think that's a safe prediction.

DR. MYERS: Given the magnitude of this issue, what should we be doing in order to get at that question that we're not doing today?

DR. WILENSKY: Let me try to see whether I can push Joe a little bit on this issue. If the major difficulty is not being able to adequately adjust for quality changes, is there a way to try to parse out through some other means what we think the quality effect might be so we get a residual factor?

DR. NEWHOUSE: If you think about what we've done on the physician side. PPRC near its end of life generated this long list of process measures to see if there was any change on those, and it went around and looked for hot spots and problems in access and so. We've never really done the analog of that, I don't think, on the hospital side.

If I were going to answer Woody, I would say probably you need to think along -- you can't do the exact analog, you wouldn't. But it's probably along those lines. I mean, you would try to look for some sense of is the payment inadequate? Is it more than adequate? I mean, in the PPRC case you were looking at is it inadequate or for some things in some areas is it inadequate?

That's always going to be an imperfect process because you're trying to run what is inherently a quasi-local program at 50,000 feet. That's how I would answer your question.

MR. GUTERMAN: As somebody who's been through this process for a number of years, I can tell you that some of this stuff that you've seen today is appropriate to look at. I mean, it's not going to give you the answer to the question, but I guess part of it is the Commission has to decide what question it's trying to answer because there are lots of situations that you'd have to figure out how to address. For instance, if quality is going up and it also makes things cheaper, do you want to pay less for higher quality that's cheaper? Do you want to pay more for higher quality that's cheaper? Or not as much more?

But the notion of the framework that we're presenting you with is that there is generally an allowance for quality increasing cost increasing change because you want hospitals to have the money to be able to adopt the quality increasing technology and procedures that will help Medicare beneficiaries. There is a notion that hospitals each year should be able to improve the way they do what they do so that for a given product that they produce they should be able to produce it cheaper every year.

And then there's another notion that you should periodically examine the base payment rate that you pay per unit of product to make sure that what you're paying for as a program corresponds to what you're getting for what you pay for.

Now all of these analyses can't give you the answer to any of those questions. What you have to do is be able to take the information that you get and apply it in a way that seems appropriate for you because one of the drawbacks of a prospective payment system is that you're setting a rate in advance and you don't have the information you need to really tell if you're going the right thing.

Even this kind of thing, the notion of product change or site of care substitution, whatever you decide to call it, is a notion of looking at what we're paying -- it's not what we paid in the past. It's what we pay now and whether what we pay now is appropriate as a base for the update that you're going to apply. And if it needs to be adjusted you can build it into the update process, that adjustment.

So it's hard to tell what kind of information you're going to need that gives you the answer because basically there's no information that can give you the answer. There's only information that can help you form an impression of what the right answer is.

DR. NEWHOUSE: By the way, I think whether we retroactively adjust for the site of service thing is one question. There's no question in my mind that we should prospectively adjust for what

we think is going to go on in the future. That is to say if we're paying for a certain bundle of services that we label a hospital discharge and now some of what's in that bundle of service migrates out the bundle and off into the post-acute area, then we should adjust the payment for the bundle accordingly.

Now the fact that we didn't do that consistently in the past, I say that's one question, whether we should go back. I'm inclined to think personally we should not, but reasonably people could probably differ. But that we should do it in the future I'm convinced of.

DR. WILENSKY: If we can figure out what to do.

DR. NEWHOUSE: If we can figure it out, that's right.

DR. CURRERI: I have a little ambivalence because I'm not sure what we're going to do with this number no matter how we come to it. I mean, how are we going to use this data? It clearly isn't going to have any effect on reimbursement of hospitals because that's legislated. And unless there's a legislative change, I don't see it.

So are we going to use this to compare against the mandated, legislative changes and see which one is more accurate? What are we going to do with this after all this work and all this consideration?

MR. ASHBY: Let me respond to that. I think that we have gotten lots of feedback that the Congress does appreciate our estimate of the appropriate update because they recognize the shortcomings of trying to legislate this five years in advance, but they feel the need to do it within the larger budgetary picture.

But as they readdress these questions in the future, which conceivably could be for next year's or it could be for two years down the line or four years down the line, they will presumably go back and consider what we had to say about the appropriate updates over these course of years as they make the decision for the next round. It's potentially very valuable input to them in doing that.

DR. CURRERI: But Jack, how are we going to compare which figure is more accurate, Congress' figures or our figures, assuming that they're different? What are we going to do with this data and why would Congress think our estimates are any better than their estimates unless we have some way to actually look at whether they predict anything?

MR. ASHBY: Hopefully they would consider ours to be the better estimate in the sense that it was developed through the A factor framework that allowed us to consider all of the relevant considerations. It's still far from perfect, because as everyone has been saying there are judgment calls to be made even on the factors that influence cost. But hopefully that's one step better than making the judgment on the total and running with it.

DR. CURRERI: So what you think then is that the next time either there's legislated fees or something that they would take this into the account in some retrospective way to correct for errors that are in the present legislative mandate? Is that where you're coming from?

MR. ASHBY: They could choose to do that and they would have the input available to them.

MR. MacBAIN: I think if you look at the figures laid out in the Balanced Budget Act, for fiscal year 1999 it's market basket minus 1.9 and then for 2000 it goes to market basket minus 1.8. And then the adjustment drops to market basket minus 1.1. Well, that's a political number. That's not based on a lot of deep analysis. And then it goes to straight market basket after 2003.

Both of those points, I think, are sort of open invitations to re-examine the number at that point. And if we have been able to establish a record of analysis in the intervening years, then Congressional staff has some data to fall back on to figure out where it really ought to be.

DR. CURRERI: Let me just respond to that. I don't disagree with that at all. And I don't disagree that this is a valuable exercise. The thing I want to stress is that we need to do something

with this number. And what I'm saying is we make these estimates and maybe we do this, I'm just not sure, but do we go back two years later and say how good were we?

And if we weren't any good at making a true estimate, how would we change this model or how the input into the figures for the model be improved?

DR. NEWHOUSE: That's essentially what Jack has been doing with his site of service number. He's said how much of this -- there was, if you will, bias upward by ignoring the shifting of services out of the bundle. And how much of that has now been "recaptured?"

MR. ASHBY: I think the essence of it is that it's one thing to say that we set implicit or explicit productivity adjustments in the past and the industry beat it. It's one thing to say that, they obviously profit by it.

It's another thing to say that we failed to recognize that these costs were going to be shifted over to another setting where the Medicare program is still going to have to pay for them dollar for dollar, so that the idea of retroactively adjusting for that -- not retroactively in terms of taking the money back but retroactively in terms of reestablishing the right set of payments for the future is a whole different concept than going back and saying well, we didn't shoot high enough on the productivity adjustment therefore we're going to shoot higher next time to make up for it.

The latter just does not seem appropriate to us, but the idea of readjusting for those dollar-for-dollar shifts that Medicare ends up having to pay for every dollar of those does seem appropriate somehow. But still, it is a judgment call. That is for you to decide.

DR. CURRERI: But it seems to me we can measure some of these things retrospectively just to see where we could improve our predictability. Science and technology, I think, could be measured on a retrospective basis, as product change. I agree with you, productivity probably shouldn't be looked at because that may be just due to individual effort of individual institutions.

MR. ASHBY: Not only that. We were essentially making a deal with the industry at the time that this is level of productivity gain that you should be able to achieve and if you beat it, you should be able to keep the difference. But no one ever suggested a deal like that, that if you are able to shift part of the content of your discharge over to something else you should get paid for it twice. No one ever said that's the way it should be.

DR. NEWHOUSE: Anybody else want to --

MR. GUTERMAN: Let me just amend what I said a little bit. I believe the deal was if you beat it in that year you can keep it in that year and that no one's saying that if you sign a contract in 1984 and you find, even without the shift in services, if you find that computers don't cost $5,000 anymore they cost $1,500 and they're a better product, no one's saying that you should continue to pay $5,000 for that computer.

No one's arguing that you're getting shortchanged, it's a better product, but the fact is it's cheaper to produce and your price should correspond to the costs of producing the service.

DR. NEWHOUSE: Anybody else want to get in on this? Jack, do you want to ask any further questions?

MR. ASHBY: No, just to comment that we would find it very helpful if you would give us a direction, first of all, on the names of these adjustments. Second of all, confirmation that our narrower scope of the site of substitution is okay.

DR. NEWHOUSE: How about this as a compromise? You label it through-put and then beside that, in parentheses, you put productivity in quotes?

MR. ASHBY: And we would go on to explain why the term, of course.

MR. JOHNSON: Would this be like naming a constellation or star? We could just call it Jack's factor.

[Laughter.]

DR. NEWHOUSE: All right, I think we'll then go on to ambulatory care. Jim?

DR. CURRERI: Could I just make a comment? I think you wanted some input not only about productivity but the change in name from product to change of site or whatever and the narrowing of that. I, for one, am perfectly happy with both of those things.

DR. NEWHOUSE: I am, also.

DR. LEWERS: Except to note the vice chair kept saying site of care to site of service and that's going to be confusing.

DR. NEWHOUSE: Site of care.

DR. MATHEWS: Good afternoon. I'm happy to be back up here, as always. It seems like we go too long before getting together. I think this holiday season I've spent more time with the Commission than I have with my wife and my dog, a fact for which they are profoundly grateful.

I'm here to talk about rationing -- I mean rationalizing Medicare payment for ambulatory care.

[Laughter.]

DR. MATHEWS: Rationing is next month's presentation.

The impetus for this presentation is to try to bring together some thoughts that you've been developing over the last year related to the BBA's mandated changes in Medicare various payment policies for ambulatory care.

There are several big ones that have been proposed since the summer, changes to the ambulatory surgical center payment system, revisions to the practice expense component of the Medicare fee schedule for physician services, and the hospital outpatient PPS.

This latter is particularly noteworthy because it is such a complete departure from the prior law payment system, which was sort of a mosaic of aggregate retrospective cost charge and blend-based payment methodologies.

Under the new system, which is a prospective system, payment for hospital outpatient services will be known in advance at the time they are rendered for the first time in the program's history. Since many of the services provided in hospital outpatient departments can also be provided in other ambulatory settings, the OPD PPS payment rates can be lined up with those for the other settings, possibly creating financial incentives in the provision of ambulatory care.

There are a number of other policies raised by the transition to the outpatient PPS and the relationship with these payment changes to those transpiring simultaneously in other settings. So again I would like to try and bring together at least my understanding of some of your thoughts on these issues.

They come from your discussions over the last several months, from your comment letter on the ASC payment system changes that you sent in August, your March report from last year, there are some carryover recommendations that you might like to consider this time around, and also see if we can wrap up the current draft comment letter on the outpatient PPS.

There are a lot of recommendations, I think nine or 10. I have divided them into three general categories. First is ambulatory care in general. These are recommendations that would apply to any and all ambulatory settings. There are several recommendations specific to the mechanics of the hospital outpatient PPS proposal from HCFA. And finally, there is one recommendation specific to the changes in the ASC payment system. If we can keep our discussions focused, I would like to work through these one by one to see if we can dispatch them in sequence.

The first general recommendation deals with the unit of payment, which is the bundle of services the payment is intended to cover. Both in your March 1998 report and the ASC comment letter, you've indicated that the unit of payment should be the individual service which consists of the primary service -- that is the reason for the visit -- and those ancillary goods and services necessary and essential to providing the major service.

You've also indicated that this payment unit should be defined consistently across all settings. And I believe the language in the proposed recommendation and the OPD comment letter does reflect this point of view.

HCFA's proposal for the ASC payment system revisions and the hospital outpatient PPS revisions are consistent with this approach, at least in the short term. They do have an explicit desire to expand the bundle of payment in the future and this might be an opportunity to see if I've got your sense of this issue right.

The next recommendation deals with the calculation of relative weights that correspond to the unit of payment under various ambulatory care systems. Previously you've indicated that HCFA should calculate relative weights using costs to individual services not groups of services. And again, these relative weights should be calculated consistently across ambulatory settings.

At the last commission meeting, some of you tempered the first statement by indicating that it's not groups per se that are objectionable, but rather in their application in one setting and not all of the others.

As it stands, this recommendation is distinctly at odds with HCFA's proposals which do invoke a grouping mechanism called ambulatory payment classifications or APCs to calculate relative weights. HCFA has proposed grouping services in both the ASC and the OPD settings. It has public espoused such an approach in physician payment.

The third recommendation invokes the general principle of consistency of payment across settings and it's rooted in the historical discrepancy of payment amounts for the same service when provided among different venues. We've been concerned about this because of the ability to provide any ambulatory service in any setting and the potential for payment changes to create incentives that would outweigh clinical appropriateness.

Thus, we recommend that the payment amounts under both the outpatient PPS and the ASC PPS should be evaluated concomitant with payments for services in physicians' offices under the revised Medicare fee schedule where relevant to ensure that unintended financial incentives are kept in check.

HCFA does recognize the value of consistency of payment in that they have proposed using the same classification system in both ASCs and OPDs. However, the data used in each of these endeavors was collected independently from historically and operationally disparate sources. Further, the extent to which HCFA analyzed the data concomitantly across settings is unclear and the relationship between payments in these settings and those applicable in physicians' offices was not reported.

The Commission may want to recommend that the agency explicitly evaluate costs and payments across these settings.

MR. JOHNSON: On this slide, have you actually found -- you used the word the hypothetical incentive, I believe. Have we actually found, based on evidence so far, that there is some sort of problem here? I thought there was very little cross-site substitution in procedures.

DR. MATHEWS: That is my sense of the data. However, there are a number of coverage changes that are also occurring, particularly with respect to the ASC payment system, where eligibility of those services to be provided in ASC is being loosened up a little. And that could indeed result in a migration of services to that setting.

MR. JOHNSON: From?

DR. MATHEWS: From the physician's office setting. There's a recommendation specific to that in a minute we can talk about. As you'll recall previously, our data has shown that there does not appear to be a particularly strong link right now between the share of ambulatory services provided in a given setting and the corresponding payment amount for those services. But the potential does, of course, exist and it's something that --

MR. JOHNSON: But it's not from the physician or the ASC to the OPD? Is there an incentive there?

DR. MATHEWS: Not in a way that we can easily document.

MR. JOHNSON: Thanks.

DR. WILENSKY: I think the concern is that if we're not mindful of the incentives that we put in place, we want to make sure that we have incentives that are neutral, having adjusted for things that we think are appropriate. If you put incentives in place that would otherwise incent to have a procedure done in a particular place because of the payment and not the appropriateness, it is possible that it won't happen, but that will be by sort of dumb luck.

You want to make sure you don't have something in place that encourages inappropriate selection because of payment base.

MR. JOHNSON: Actually, from everything I've observed, everything seems to be moving in a direction and I haven't really seen an incentive that would change that. I'm just not sure what we're chasing here, but let's finish the presentation.

DR. WILENSKY: I think that that discussion, and also the discussion we had this morning, which is pulling the various pieces of the hospital together, are somewhat at odds with each other. We need to have some discussion on that. Continue please.

DR. MATHEWS: The fourth general recommendation deals with the sustainable growth rate or SGR system. We did talk about that a bit this morning, and fortunately my language here anticipated that discussion. As you indicated, you believe that HCFA should develop and implement a single sustainable growth rate system for all ambulatory care services that would apply to hospital outpatient departments, ASCs, and physician services under the Medicare fee schedule and other ambulatory services as appropriate.

The ambulatory SGR system would be designed so as not to unduly restrict the migration of services from inpatient to ambulatory settings or among ambulatory settings as appropriate.

This recommendation, if approved, is at odds with HCFA's preferred approach which is an SGR modeled after the physician SGR but one that would apply only to the hospital OPD setting. It would parallel the physician SGR in structure but operate independently of it.

The last of the general recommendations revisits the question of differences in payments across settings. At the last meeting you indicated a strong preference that differences in payment be pegged to differences in patient needs and clinical status rather than historical differences in facility specific payment policy.

This approach advances moving away from sector specific or the silo specific reimbursement policies towards reimbursing for procedures and for patients. So logically this same principle would apply across ambulatory settings as well as within. There is, as you know, no viable beneficiary level adjuster that could apply in a fee-for-service ambulatory care world at the moment. Therefore, I think we've written the recommendation to indicate that HCFA should begin to evaluate the means of adjusting payments at the beneficiary level. We could change that as you see fit.

DR. LONG: Meaning what, Jim? To take into consideration the medical status of the beneficiary?

DR. MATHEWS: I believe, if I understood the gist of your discussions over the last couple of months, and particularly at the last meeting was that we wanted to get away from reimbursement which had the phenomenon of different rates for the same service provided in different settings and move towards a scenario in which any differences in payment rates were pegged to the particular costliness of providing those services to the beneficiary, rather than the setting in which it was provided.

That's what I've tried to capture here but there might be a better way to say it.

DR. KEMPER: When you say patient characteristics, you mean severity or comorbidities rather than demographic--

DR. MATHEWS: Exactly.

MR. MacBAIN: I think we're saying for services that could be provided either in a doctor's office or in a hospital OPD. Generally the patients receiving a service in the OPD are likely to be sicker and it's a more complex process. It should recognize a higher level of expense.

DR. KEMPER: I was just reacting to the term patient characteristics in the language, to be clearer about what that is.

DR. LONG: Let me explore that a little bit. If you set a given payment rate for a given procedure, then that would suggest that the economic incentive would be to always do it in the lower or lowest cost setting, which would tend to be inappropriate for the patient with the comorbidity. If on the other hand, you set it for the patient with the comorbidity and the more complex setting, then the well patients are going to tend to be treated in that setting, too.

It seems like it's a binary decision in which you're always wrong one place or the other.

MR. MacBAIN: Although we're not talking about one entity making that choice. Generally, it's the physician who's going to make the choice. If the physician is indifferent in terms of the net income derived from doing it in the office or in the OPD, then presumably it's patient's need that will dictate where it's done regardless of the total cost to Medicare.

So Medicare may pay more in total for the physician service plus the OPD for the more complex patient treated at a hospital.

DR. LONG: Professional component and not --

MR. MacBAIN: Yes, professional in the OPD which would not include the practice expense plus the OPD payment may be greater than physician payment plus practice expense in the office. But if the net realized by the physician is roughly the same in each case then we don't have the concern of having everything go to the site that has the higher total cost to HCFA.

DR. MATHEWS: My sense was that you wanted to get away from differences in payment rates that were pegged to facilities, so that for example in 1996 a physician would be reimbursed $17 for providing a chest x-ray in the office setting as the practice expense component of the payment. The same service, on average, would be paid something like $31 in the hospital outpatient setting.

Now ostensibly that $31 payment rate would be institutionalized as that fixed amount, or some function thereof, under the new outpatient PPS and that would become the hospital rate. So what I have understood your conversations to indicate is that you do not want a hospital rate of $31 and a physician office rate of $17, but rather you would want there to be a rate for that chest x-ray which could be adjusted according to the severity of the beneficiary's condition, the costs that would be required to provide that service to that beneficiary.

Again, I would point out that there is no such means of doing that right now.

MR. JOHNSON: Just sticking with that example for a moment. Who would make the decision of whether you do it in the hospital OPD, the ASC, or the surgeon's office?

DR. MATHEWS: My guess would be the primary care physician.

DR. WILENSKY: Presumably who makes them now?

MR. JOHNSON: My only point is, I'm not sure what we're trying to incentivize here in terms of who's making the decision. For example, when we talked about quality previously in measuring the quality, if there was more severity with a particular patient, I would assume you'd kick them into the hospital OPD for some reason and that would be higher quality, which you would also assume might receive a higher payment.

DR. WILENSKY: When we had talked about this before, as I had recalled it, it wasn't that we thought there would be higher quality but that some of the people who are more likely to be seen

in the OPD were because they had comorbidities. It wasn't that we thought they were getting higher quality care, but to the extent that they had two or three comorbidities, having any service done required a more intense effort and therefore should have a higher payment.

MR. JOHNSON: If they didn't have it in the hospital, would it be less quality?

MR. MacBAIN: For the complex individual, yes.

DR. WILENSKY: But not for the x-ray. We certainly don't want to be in a position of saying that in order to have a higher quality x-ray we have to have it in an outpatient. It's just that if you have a combination of morbidities, that may be taking account of those comorbidities is what would have higher payment.

MR. JOHNSON: I guess I could argue with you, depending on whether or not the institution had to have its x-ray machine inspected and certified versus one at some other location that might --

DR. WILENSKY: I think that's actually an issue that I would like to take up in general, particularly as we've been talking about some of the requirements for PPOs in network plans, is that the focus that we put on the networks as opposed to traditional fee-for-service is producing potentially very different quality standards in ways that make very little sense when you recall that 87 percent of the seniors are going to the places where we tend to have lower or at least not as explicit standards, that is in the traditional Medicare.

DR. CURRERI: I think we have to be very careful though about ascribing that the various sites are there and by and large take care of -- as the cost goes up -- of patients with more comorbidities. There are many reasons that a physician will choose one particular site or another.

If we take your x-ray example, as a matter of fact, it may be the physician doesn't have an x-ray in his office. Or it may be that he is restricted from having x-ray because he doesn't have appropriate protection for people around him. Or it may be that he can't afford the liability of having an x-ray.

The same is much more true with invasive procedures because there you have to have a sufficient volume of invasive procedures to justify having all of the resuscitation equipment, the potential for post-operative intensive care and so forth and so on available. So that the site selection, I think, is going to differ very much depending on geographical area, depending on volume of services provided in the site, and on comorbidities.

So I don't think we can always make the assumption that a patient that goes to the hospital outpatient department is going to be more ill or more sick. It may be that the referring physician is one that has relatively low volume and is not willing to take, let's say excision of a dermatological lesion in his office because he's not equipped for it and doesn't have the staff to assist appropriately, and he doesn't have anesthesia standby and all kinds of other things that come into play.

So it's not just comorbidities and illness of the patients that enters into site selection. I think you'll find it's very different in rural versus urban areas, too. There are many who practice in urban areas that essentially do very little in the way of office procedures and refer all of them because it's relatively simple to a hospital outpatient department or an ambulatory surgical center whereas in the rural area there's much more propensity to do a lot more things in the office simply because it's not very easily accomplished in another institution.

DR. WILENSKY: Jim, I think what's clear is that our principle is easy to articulate and the question of how we can operationalize this is going to be more difficult. But I think the question that we need to make sure that commissioners are comfortable with is our preference about going in this direction to the extent that we can, as opposed to accepting what may have been historical differences for a variety of reasons and not questioning whether or not the relationship for providing what we believe are similar services make sense.

DR. MATHEWS: Right. I do go into this issue in a little bit more detail in the outpatient comment letter in which there is a little bit of a hedge in there but we can talk about that in a minute, and see if that helps the Commission decide in the larger ambulatory setting question. But I do understand your general principle correctly then.

DR. KEMPER: I guess I have a concern that I don't have the answer to but we're thinking about conditions that can be treated in all three settings and cities where all three settings are available. Jim's very nice paper provided a lot of evidence that says the world's a lot more complicated than that, both with respect to conditions but also with respect to geography.

I guess what's troubling me is what happens in say a rural area where maybe the hospital outpatient department is the only place where the procedure can be done within a reasonable number of miles? And let's say the model that our thinking comes at there's a higher rate for more complicated cases that are appropriately treated in a hospital outpatient department. That doesn't apply if those other choices aren't there.

I don't see how that gets handled within this kind of a framework. I don't have a solution to it.

DR. MATHEWS: That is exactly the point of that paper, or it's one of them, that I was trying to make.

DR. KEMPER: It's a very nice paper. I hope some of it can get into the report, but I don't know where to go with it, in terms of...

DR. CURRERI: I guess I don't have so much of a problem with that. It's going to cost more if you're in a rural area that has only one place to treat and you don't have competition between the different areas. That's the price of low population density, low volume. And Medicare is going to pay more for that.

DR. NEWHOUSE: No.

DR. KEMPER: That's the problem.

DR. CURRERI: No, Medicare is going to pay more if the costs are higher there, right?

DR. MATHEWS: No, not any more.

DR. NEWHOUSE: That was the old days.

DR. CURRERI: Look at the second line.

DR. NEWHOUSE: Yes, but that doesn't say between outpatient departments in rural areas and outpatient departments in --

DR. CURRERI: Oh no, I wasn't suggesting that. I was suggesting that if the cost in an outpatient facility is higher because of the costs of providing that, and that's the only thing available in the rural area, that's the cost of taking care of somebody in the rural area if that's the only place you can treat them.

DR. KEMPER: I thought the recommendation meant that there would be a lower rate, at least for some procedures, that was established by the physician's office or the ASC, which was lower in general than the outpatient department, and that that rate is what the outpatient department would get paid, even if that was the only setting in the geographic area where it could be done.

Maybe I misunderstand what the recommendation says.

DR. NEWHOUSE: I think this bears on that, but I want to start out by making -- which I'm going to continue to make for the rest of my marks -- the benign assumption that the hospital in total should be collecting the amount of money it's now collecting through some "legitimate set of costs" that Medicare ought to be paying to the hospital. How much money in total it pays is obviously both a contentious and a difficult issue.

Now we went through Stuart's presentation this morning and Stuart, at a couple of points, said that well, these high PPS inpatient margins may be because hospitals have shifted costs out of

their inpatient base and accounted for them over in the outpatient department and also that may be why outpatient margins are negative.

That is what one would have expected, given the old regime where outpatient was cost reimbursed and inpatient wasn't. I mean, a rational hospital should have done that. So that's been done. And then the set of prices that we now have, when Jim says it costs -- or when we say, for the same of argument, it costs $31 for the chest x-ray, that now reflects the allocation of those costs.

My question is, and I think this discussion has been on point, but I ultimately think we need a study like Jim did with the ASCs. To what degree do these different prices actually affect the choice of site? I mean, if they don't much affect the choice of site, then this is probably a good way to give hospitals money again assuming that you think the hospitals should get money, because it's not distorting behavior.

But I think the principle here was the fear that it would affect the choice of site and the issue is are there any empirical data on this? I read the ASC paper actually the other way, as saying where all these things exist indeed the payment differential may well affect the choice of site.

DR. CURRERI: This is the question that I have in my mind and it reflects on something Bill MacBain said before. Is it true that under our proposals that if you were a physician and you did something in the hospital outpatient department and/or the ambulatory surgical center in lieu of doing it in your office, that you would be paid CPT rate minus practice expense? Because that's what Bill MacBain was saying before, I believe.

DR. WILENSKY: You got something.

DR. NEWHOUSE: Half of the site of service differential.

DR. CURRERI: It's 50 percent then. It seems to me that, to many respects, evens all this out because it reduces the professional component, even though the institutional component may differ slightly from one place to another.

DR. WILENSKY: George, do you want to try to help is out?

MR. GREENBERG: George Greenberg, ASPE at the Department of Health and Human Services.

This is complex and I think Joe said the question exactly right. Now the question is is there a behavioral difference? And I don't know of any research on this, nor do I have any true wisdom on it. But it seems to me, to frame the question, is that what is said about the professional component is absolutely correct.

Nevertheless, in a world in which physician and hospital organizations may in fact become more frequent or horizontal integration in general occurs in the industry, that it may be that the physicians themselves have an interest in the institutions and therefore the institutional service can influence choice.

I probably believe personally that most physicians reside in communities where the hospital or the clinic or the whatever is someplace that they themselves have some stake in, whatever those arrangements are. So even under the current system you could see scenarios where these large price differences that Jim has documented could make a difference in the choice of service.

But what the actual reality is now, what it would be next year, what it would be the year after that, I don't think anybody knows.

The other thing that helps me think about this is when -- before the OPD reg and ASC reg that HCFA has issued came out, there originally was supposed to be a physician practice cost component of the fee schedule that would have been implemented as we speak if it had been on its original schedule. And at one point, there was some thought given to the notion that well, you've got the practice costs for a physician office, you could pay those in other settings. And that would have, of course, leveled the playing field and create comparability.

But then the question arises in fact, because as Joe says how do you make the hospital whole? How do you make the ASC whole? Is there a difference either in the case mix or in the true costs of those facilities that would justify additional payment?

That would be a fairly simple system, but in fact that whole question was put off because that hasn't happened yet.

DR. WILENSKY: We'll come back to this.

DR. MATHEWS: We're going to get into recommendations that are specific to the HCFA OPD-PPS proposal, the first of which, I believe, is one that there was good consensus on among the commissioners.

HCFA has proposed to use ICD-9 diagnosis coding both to calculate relative weights used in payment and to make payments under the new system once everything is put into place.

There are a number of both data and conceptual problems with using the diagnosis code as a factor in payment, which I believe led you last time to recommend fairly strongly that HCFA not use ICD-9 diagnosis in this manner, but instead should pay on the basis of the HCPCs coded medical visit indicators, which do have complexity built into the code itself.

DR. WILENSKY: That is what we said.

DR. KEMPER: I guess the one comment I have is that it be worded in a way that makes it clear that diagnosis might be one of the patient characteristics that HCFA would evaluate in terms of the costs. It could be construed as inconsistent with the previous recommendation?

DR. NEWHOUSE: Which previous recommendation?

DR. KEMPER: The one just before said says the rates ought to depend upon patient characteristics such as severity, comorbidities, whatever it is that might drive the cost of the procedures. And then the next recommendation is don't use diagnosis. Well, diagnosis would seem to be a severity measure.

So this recommendation is in a particular context of what -- so it just needs to be clear that it's not --

DR. MATHEWS: Right.

MR. MacBAIN: The difficulty is which diagnosis gets attached to the service and does that have anything to do with the reason that you're doing it on a more or less expensive site? I would guess in most cases it wouldn't. It's a guess but at least in enough cases that it would make a very poor proxy for what we're trying to get at.

I think you mentioned earlier, there really is not a good measure for what we're trying to get at which is the overall complexity of an individual patient.

DR. MATHEWS: Right. It's very difficult to measure even in the long term sense, much less the acute sense, as reflected in 90 to 100 million Medicare outpatient claims per year. You might recall some work that Chris Hogan when he was a staffer on the commission here that showed even tracking the incidents of something relatively immutable like quadriplegia had a fair amount of variation year to year, even when reporting for the same patient.

So if you started to do it on very acute diagnoses related to the outpatient encounter, such as rule out MI versus heartburn, it might be subject to -- there's a correct way of saying this and I won't try.

DR. LONG: Let me ask this. When we start talking about patient's overall characteristics, comorbidities, et cetera, are we assuming that means that a patient of lower health status or more complexity is going to be more expensive to provide any given service? Or are we talking about the contingency planning that you ought to be doing this in a hospital OPD in case something goes wrong? In which case, it would seem to me that you're going to be paying more anyway if something goes wrong because those are going to be different procedures and different payments.

DR. MATHEWS: At our last meeting Jack Rowe came up with an example that kind of stuck with me and it's been a useful touchstone in thinking about this. It was two patients getting an x-ray. One is a younger beneficiary, relatively healthy, has all of the functions of daily living. Stands in front of the machine, hold your breath, snap the picture and walk out.

The other example that he gave was the frail, demented, somewhat incapacitated individual who might require an orderly to help stand, who might have to have a couple of films taken before they get a good picture. The cost of providing that service with the same code would be different.

And it would be those costs that you would want to reflect, or the differences in cost attributable to that patient's characteristics, especially as they pertain to getting that service, that you'd want to reflect in payment rather than the historical payment tracks that applied to the setting in which it was provided.

DR. KEMPER: I also think that the standby capacity is presumably invoked in only a small percentage of cases but it's still there for the others.

DR. MATHEWS: The next slide. This one seems a little more vague but it is important on several broader planes. In last year's March report you recommended that given the magnitude of the payment impacts of the BBA's combined ambulatory provisions on hospitals relative to prior law, concomitant with all of these other changes in payment policy that are taking place, that HCFA should closely monitor hospital outpatient service utilization to insure that beneficiary access to appropriate care isn't compromised.

Now we have a better idea of exactly what these impacts will be. As we've demonstrated previously, aggregate payments to hospitals for outpatient services will fall from about 90 cents for each dollar of reported cost to about 79 cents on the dollar once the BBA's provisions are fully effective.

Now at the same time, there are significant payment policy changes taking place in physician setting and the ASC setting as well. So all we are saying here is that we need to see where all the balls come down and try and catch them before they hit the floor.

A moment ago we talked about a recommendation dealing with consistency of payments across settings, this again being the principle that payments should reflect the costs of treating individual patients who receive particular services. I think if we agree that this principle should apply in trying to resolve differences in payments across settings for the same service it might also apply in resolving differences in payments within settings.

So to the extent that the hospital outpatient PPS payments might be adjusted to reflect the beneficiary characteristics such as severity of illness, co-existing conditions or comorbidities, it might be done within the hospital setting as well. Again we come back to the problem that it is next to impossible to do with currently available data.

So I did include language in the draft comment letter to the effect that if we can identify classes of facilities that wholly treat homogenous populations of patients who we believe are particularly vulnerable or who do require such additional resources in providing their care, we might use such adjustments as proxy but that it is with serious reservations that we would recommend this; one, because our stated preference is to do the patient level adjuster. And two, once you do put other sorts of broader adjustments in place it is next to impossible to get rid of them.

So it's the hedge I was talking about earlier and it does give HCFA something of a utility to help them mitigate some of the impacts that we've seen previously. But if your preference is very, very strongly to go forward with the payment level adjuster, we could take this out of the outpatient comment letter.

MR. JOHNSON: My preference would to leave it in.

DR. NEWHOUSE: What does HCFA say about this point? They're not concerned about it?

DR. MATHEWS: In their proposal, they do propose adjusting the payments for the cost attributable to variation in local wages. I believe 60 percent of the rate will be adjusted by the hospital inpatient pre-reclassification wage index. They've proposed no other adjustments.

DR. NEWHOUSE: I understand that. But when asked, why not, what do they say?

DR. MATHEWS: They have concerns about the validity of the underlying data used to develop the system.

DR. NEWHOUSE: That would seem to go beyond this little point.

DR. WILENSKY: You seem to have trouble saying that for a straight face.

DR. MATHEWS: Well, if you're in for a penny, you're in for a pound. If you believe the data is good enough to come up with a comprehensive proposal like this, it's got to be pretty good.

MR. MacBAIN: I want to go back to the graphs that Stuart showed us this morning and think about this in the context of overall Medicare margins of, let's say it's 2 percent, in an environment where it's going to be harder for hospitals to go back to the commercial sector as they did the last time Medicare margins started to deteriorate, and think about the impact of the outpatient adjustments.

And particularly for rural hospitals, the combined impact of this and the change in SNF payments on hospitals that are dependent upon Medicare outpatient payments and either hospital-based SNFs and/or swing beds for a significant share of their income. I think that kind of moves beyond the Commission's own silos analytically. But I really think that's an area we need to take a look at is specifically the rural hospitals where a lot of these changes are going to hit simultaneously.

I know I've said this before, and I'm probably getting redundant, but I'll keep saying it until I start seeing some data on it because it concerns me.

MR. JOHNSON: But there is a significant compounding effect.

DR. LEWERS: But Jim, back on the recommendation, where we stated that payment differences across setting reflecting cost of providing services to beneficiaries, this fits into it. For instance, in my area where we have a rural hospital with a very large population of end stage renal disease because of large dialysis units, their costs are going to increase in doing these services. So somehow you have to recognize that.

That's how I read this. Now if that's not what you mean -- and I don't know how you do that on an across-the-board factor. But somehow you have to recognize that cost.

DR. MATHEWS: Right, that's the conflict I guess between the non-availability of the elemental data that you'd need to do it at the beneficiary level versus a reluctance to do wholesale adjustments for certain types of facilities or certain geographic regions. It's something that we're trying to walk a fine line here and I don't know if I've fallen off that line or not.

DR. LEWERS: We'll find out.

DR. MATHEWS: This last recommendation specific to the hospital outpatient setting is a little problematic. I don't know what to do with it and I put it up here hoping that you would. It relates to the beneficiary coinsurance liability.

As you'll recall, because of quirks in the historical payment system that Medicare uses, the liability is 50 percent of the total payment to hospitals compared to about 20 percent that they're on the hook for services in most other settings. BBA does correct this albeit it very slowly. It does buy down the coinsurance liability
to 20 percent, but because of the cost involved the BBA does string it out for quite some time. In March of 1998 you recommended a faster buydown. HCFA has not taken action on that, correctly pointing out that it would require legislation to do so and there has been one.

So I don't know if you would like to revisit this, repeat the recommendation, let it drop. It's your call.

DR. WILENSKY: I'd like to repeat the recommendation.

DR. LONG: I'd like to repeat it, yes, absolutely.

DR. LEWERS: Yes.

DR. CURRERI: And this recommendation is really to Congress, is it not?

DR. WILENSKY: Absolutely it's to Congress.

DR. LONG: Say it more strongly the second time?

DR. WILENSKY: Congress has indicated that on some issues like on home health care, when it chose to find more money, it could find more money. This is an area where I think there was very strong agreement that we are inappropriately burdening the seniors and we ought to make it again, unless we've changed our mind.

MR. MacBAIN: Is the implication here that Medicare would fund this or the hospitals would fund it?

DR. WILENSKY: No, this is Medicare. No, this is not coming out of the hospitals.

DR. MATHEWS: I believe we could provide some data to go along with this recommendation on the growth in Medigap premiums. There is a strong conventional wisdom that the Part B coinsurance is a very prominent driver in the rapid increases in those premiums that we've seen over the last couple of years. So I could come up with some quantifiable information to put in here, as well.

One last recommendation here, this one relates to the changes in the ASC coverage. As you know, ASCs can provide services to Medicare beneficiaries that are on an approved list of services. It's currently about 2,500 surgical procedures.

The list is largely defined on the basis of the share of the service provided in other settings. So to get on the list, to be able to be done in an ASC, it's got to be done at least 20 percent on an inpatient basis and no more than 50 percent in the physician's office. The rationale here is that you wanted to provide a lower cost alternative to the inpatient setting without encouraging the migration of office based settings into the ASC where the reimbursement would presumably be higher.

HCFA has proposed loosening these numeric thresholds in response to the community's desire to go to a more clinical determination of what is the appropriate setting in which to provide these services. In doing so, we might begin to see the kind of responses to payment policy that have been on everyone's mind since we've started talking about these things.

And this recommendation is simply saying that HCFA should keep an eye on any sort of wholesale migrations from one service to another that don't seem clinically appropriate.

DR. WILENSKY: It would really be a question of clinically necessary?

DR. LEWERS: Medically necessary.

DR. MATHEWS: Was there any additional discussion that you wanted to have on the recommendations?

DR. NEWHOUSE: I wanted to talk on the comment letter. Are you going to get to that?

DR. MATHEWS: Sure, we can do that.

DR. WILENSKY: Do you want to do that now and then do the ASC, or the other way around?

DR. MATHEWS: Our workplan was to get to the ASC paper as time permits, but the recommendations and the comment letter, I believe --

DR. WILENSKY: Why don't we do that first and then we'll get to the ASC.

DR. MATHEWS: I've got nothing to present on it.

DR. NEWHOUSE: This won't be helpful to the audience but to the commission, my first problem was on the bottom of page five where we're now talking about the growth. If we constrain payments we may constrain migration of services from inpatient settings to less costly ambulatory settings.

You have a sense right at the bottom that says our concern is mitigated by the historically high inpatient margins. I just didn't understand that sentence.

DR. MATHEWS: I've heard it said, not necessarily among this commission, that we don't need to worry about low outpatient margins because hospitals are doing okay on the inpatient side. I don't really think that's an acceptable way to run a railroad but...

DR. NEWHOUSE: But this went to the level of payment under the outpatient PPS and it seems to me that could constrain this irrespective of margin. I'm not sure why you were bringing up margins here.

DR. MATHEWS: Basically the thought here is, as we've indicated, hospital outpatient departments are, in the aggregate, going to be reimbursed at about 80 cents on the dollar under the new system. People have said that well, those costs are inflated, they're not real because of the shift in accounting costs from inpatient services that is evidenced by the very strong inpatient PPS margins. Therefore, this is not as much a cause for alarm as it appears at first blush.

If that's the case, then you would want to look at the hospital's overall Medicare margin in assessing its performance here. And if you wanted to do that, look at the bottom line, maybe you should --

DR. NEWHOUSE: But you're talking about a further reduction. Whatever has been true in the past, the change will be to reduce outpatient relative to inpatient. That's the burden of getting rid of the formula-driven overpayment.

DR. MATHEWS: Right.

DR. NEWHOUSE: So that will work in the direction of the concern. I guess for that to be not a concern, you would have to argue that the outpatient margin actually both in the past exceeded and in the future would at least equal the inpatient margin. And I don't think you want to argue that.

DR. MATHEWS: Right.

DR. NEWHOUSE: So I guess I'd get rid of that. Then on page six -- this gets to a Bill Curreri kind of point. This is whether there should be a facility adjustment for low volume facilities.

I guess my question was should we consider a scale or volume adjuster?

DR. MATHEWS: Or an urban/rural adjuster or something like that.

DR. NEWHOUSE: That's very cumbersome. But one could have some kind of volume adjustment. I don't see why that would be so hard. Have you thought about that?

DR. MATHEWS: One of the strongest factors that seemed to drive up per unit costs in the outpatient setting was volume.

DR. NEWHOUSE: Yes. That makes sense.

DR. MATHEWS: The question is, as a matter of policy, do you want to provide an incentive to do fewer services?

DR. NEWHOUSE: No. You're presumably -- the reason that there are these scale economies is that you have some fixed costs and then, as you do more, the average costs come down. So I would have thought you would have wanted to pay something closer to -- you would have wanted to track that coming down because that's what the cost is at the margin. I see a few people nodding their heads.

DR. ROSS: Paying to increase volume?

DR. NEWHOUSE: No, you're dropping the reimbursement with volume.

DR. CURRERI: But you also drop the costs.

DR. NEWHOUSE: The average costs are dropping. It's not clear what's happening really at the margin but the simplest assumption if your marginal cost is constant then you're getting presumably coming closer to that.

At the other side, if you don't do that, you're probably going to get rid of rural outpatient departments or small outpatient departments, I would have thought.

MR. MacBAIN: I think the issue is the price that Medicare pays is only one of a lot of determinants that feeds into the volume of outpatient services in a given hospital. One of the other things has to do with where it's located.

Regardless of what price you pay, a rural community that has a certain level of service is probably providing that service at a relatively low volume area compared to a large urban hospital. So that the costs per unit of service are probably somewhat higher. If we want to protect that rural hospital, we ought to pay more per unit of service for a low frequency facility.

I think one of the questions it raises though is do we want that across the board because it could also apply to one of two neighboring hospitals a block apart in a city, one of which happens to have an outpatient department that, for other reasons, has a relatively low volume. Do we want neighboring hospitals in the same city to be paid different rates for the same services when it's not an issue of access? So I think we need to get a little more subtle on that.

But from the rural prospective, I feel very strongly that there has to be some kind of adjustment in here to recognize that the unit cost is going to be higher but that, as a policy issue, we want to maintain that capacity to provide service.

DR. NEWHOUSE: So maybe the analog would be to the sole community hospital provisions on the inpatient side, that we suggest that there be something analogous

DR. CURRERI: I couldn't agree more. I think the last thing we'd want to do is have an incentive for hospitals to duplicate services in the same area. So I think that you have to do something like the analog you suggested, Joe. But I very much agree that the need to protect the outpatient departments of rural hospitals with no capability of increasing volume.

DR. KEMPER: But how does this relate to our recommendation that payments be consistent across settings?

DR. MATHEWS: Logically, it would follow that you would adjust ASC payments if they were located in rural areas and were the sole source of ambulatory care.

DR. KEMPER: And physician office payments?

DR. MATHEWS: There is -- I can't remember the term -- medically underserved adjustment for a particular --

DR. WILENSKY: Is that a 10 percent increase?

DR. NEWHOUSE: Also, scale may be less important there. That is to say the physician in the rural area may be as busy, in fact tends to on average work longer hours, than physicians in metropolitan areas.

DR. KEMPER: I'm not concerned about the physician's scale of economy. That isn't what I was thinking about. I was just thinking about the differential between different settings that this would create potentially.

DR. NEWHOUSE: I see what you mean.

DR. KEMPER: We have two inconsistent sets of recommendations.

DR. MATHEWS: You haven't explicitly ruled out adjustments along these lines for other settings.

DR. WILENSKY: In the wording that we had talked about earlier we allowed ourselves some flexibility to account for other factors. And I think in the case of a sole community hospital or something equivalent, where we think to not make some adjustment would do away with a service capability, that sounded consistent with the language that we had used.

MR. MacBAIN: I think we want them consistent, all other things being equal. And now we've identified a couple of things that are not equal. One is the difference in patient severity and the other is the need to protect the sole community rural hospitals.

DR. WILENSKY: It becomes an issue where you're not worrying about competitive pressures because you're trying to make sure that you keep the capacity present.

DR. NEWHOUSE: Finally, there was one sentence that I couldn't understand, which is we agree with HCFA's proposal to discount payments for certain terminated surgical procedures. If they're terminated, why are we worrying about payment?

DR. MATHEWS: Because it depends on when the anesthesia is given.

DR. NEWHOUSE: Oh, terminated, you mean in the middle of the operation?

DR. MATHEWS: Yes.

DR. CURRERI: The patient changed his mind and got up.

[Laughter.]

DR. NEWHOUSE: How did we come out on the SGR discussion, since I was out of the room at that point?

DR. WILENSKY: We haven't had that.

DR. MATHEWS: I thought we did.

[Laughter.]

DR. NEWHOUSE: I'm glad I asked. What do you think we said?

DR. LEWERS: What did we say, not what you think?

DR. ROSS: You didn't object to the statement that was put up on the screen, that there should be an overall ambulatory care SGR.

DR. NEWHOUSE: I was actually out of the room at that point, but no, I don't object to it. There's a sentence in our letter then that says we support the general principle of controlling service use to limit expenditures under the hospital outpatient prospective payment system. Now I think that could be read several ways but to me it could easily be read as saying we support an outpatient department specific SGR.

DR. LEWERS: Where are you?

DR. NEWHOUSE: I'm on page seven in the first sentence under updates volume control.

MR. MacBAIN: On page eight we recommend a sustainable growth rate system that spans all ambulatory care centers.

DR. NEWHOUSE: To just minimize confusion, I would propose to change that first sentence to omit the part of the sentence that starts with under and insert Medicare before expenditures. So it would read MedPAC supports the general principle of controlling service use to limit Medicare expenditures, period.

MR. MacBAIN: On the same topic, and given some of our earlier discussions -- and it probably doesn't belong in the March report, but maybe for the June report we could begin to raise this issue of should we look at a Medicare-wide sustainable growth rate factor, A and B together, the whole system. Look at this as one medical benefit program rather than a lot of discrete independent activities.

DR. CURRERI: Gets rid of a lot of the problem of shift of site of services.

MR. MacBAIN: Probably introduces a host of other problems, but at least we ought to look at it.

DR. WILENSKY: It does assume that you have some ability to decide when sector specific increases are appropriate and you don't want to penalize for them.

MR. MacBAIN: Right. The sector specific SGR, yes.

DR. WILENSKY: No. If you use the overall and you see a blip up that has some impact that you want to be comfortable that you're not going to go and penalize across the board. Maybe not.

MR. MacBAIN: But again there's more flexibility for providers within the system.

DR. LEWERS: And that Kevin straightens out the SGR.

On page seven, Jim, I think in the middle of the page under beneficiary coinsurance, I think our earlier comments where we were pretty unanimous, I think that sentence should be stronger regarding the faster reduction in the coinsurance.

DR. NEWHOUSE: The problem with that is that would require statute.

DR. LEWERS: I know that. We say that. We say that, but it says we're going to continue to investigate means by which this faster reduction could be affected. That's all we're saying we're going to do. I think we just said that we're going to re-emphasize our points with Congress.

DR. NEWHOUSE: But I don't know if you want to say that in a comment letter back to HCFA.

MR. MacBAIN: Right, this is the context. I think that belongs in our report to Congress, not in --

DR. LEWERS: But I just don't think this is strong enough in that they -- let them know how strongly we feel about it.

DR. MATHEWS: We could put something in there that MedPAC would support any effort by HCFA to seek legislation to --

DR. LEWERS: Fine. I just think they need to know that this carries a significant priority for us. George will take that back.

DR. MATHEWS: Is that it on the comment letter?

[No response.]

DR. MATHEWS: Tenth time's the charm.

DR. WILENSKY: Should we start the ASC?

DR. MATHEWS: We can, or we can defer it to another...

DR. WILENSKY: Why don't we have Kevin do the next one and then, if it doesn't take the fully allotted time, we'll go back to the ASC discussion.

MS. FISHER: Just a point of order, question. Karen Fisher from the Association of American Medical Colleges. Are these recommendations deemed to be approved or are they almost approved and in January the commission will officially approve them?

DR. WILENSKY: No, we will come back for anything other than the comment letters that are under a time line prior to January, we will come back to all recommendations.

MS. FISHER: In January.

DR. WILENSKY: In January.

MS. FISHER: Thank you.

DR. MATHEWS: Also, if the commissioners do have additional editorial comments, changes on the comment letter, I can take them up through Christmas Eve. I will be in the office at work, not by choice.

[Laughter.]

DR. HAYES: Good afternoon. We're here this afternoon to talk about Medicare payments for physician services and on our next slide we identify two topics that I'd like to cover this afternoon.

The first has to do with a draft comment letter to HCFA on Medicare fee schedule issues and the second has to do with Medicare sustainable growth rate systems for updating physician payment rates.

If we turn first to the matter of the draft comment letter, the letter addresses two issues; first, having to do with refinement of practice expense relative value units for the Medicare fee schedule; and the other having to do with professional liability insurance expense RVUs. These are issues that we talked about, at least briefly, during the last two commission meetings.

With respect to refinement of practice expense RVUs, I just wanted to say that in the letter we talk about two things. One has to do with the skills and expertise that we believe the participants in the process should have. And secondly, we have some thoughts for HCFA about how they could organize this refinement effort.

DR. LEWERS: We just thank you for professional liability insurance.

DR. HAYES: With respect to professional liability insurance RVUs, we talk in the letter about some instructions that we believe HCFA should provide to the contractor that they're using in the development of those RVUs. In particular, we draw attention to research that's been done on the relationship between -- well, having to do with the risk of a malpractice claim and the invasiveness of services. And we also recommend to HCFA that the contractor consider a method developed by PPRC called the risk of service method for developing these RVUs. This is a methodology that takes into consideration the invasiveness of procedures.

What I thought I would do is stop at this point and see if you had any comments on this letter. If there's anything you need to discuss, of course I can take editorial changes you have separately. But if there's some discussion of the comment letter at this time, we could deal with that and then go on to the SGR issues.

DR. LONG: Generally is it the practice or the forum to go through a lot of recitation about what it says before proceeding on to what we say?

DR. HAYES: I'm not sure I follow what you mean. Do you think that I have too much discussion in the letter about what HCFA is proposing, let's say, with respect to refinement and not enough emphasis on what we're recommending? Or what?

DR. LONG: It wasn't clear to me how necessary it is to recite what the proposal is, but that's a question of balance. It just seemed here that there was a lot of that relative to what we were saying. But that's a style question and maybe it's a protocol question.

MR. GUTERMAN: Hugh, I think it's been our practice to sort of take a, now let me make sure we've got this straight, kind of approach before we sort of comment on a particular provision, which I think this is consistent with.

DR. KEMPER: It's also useful when we're reviewing the letters to provide context for us.

DR. WILENSKY: That's for sure. Bill, do you have a comment?

DR. CURRERI: My only comments were not with any of the conclusions you came to in here. Ted, you correct me if I'm wrong, but I think that in our previous letter we outlined -- this was with the proposed rule -- we outlined two areas of data that we were concerned about. The most important one, I think, was the data that came from the CPEP committees which everybody has understood that there's inconsistencies. You don't specifically, I don't think, in this letter point that out and I think that's very important to point out, that that needs some correction.

The second, I think, is some verification of the AMA SMS, only because various specialties were really undersampled in that and either it needs to be verified or the AMA needs to come out with some expanded sampling in those areas. I think we should mention those things as priority items leading up to your recommendations. So that's really all I have to say.

DR. HAYES: That's it on the comment letter then? Thank you.

If we turn now, Jack, to the sustainable growth rate system, there's two sets of issues that I thought we could talk about here. One has to do with what I've called changes in use of needed services.

The second has to do with some technical issues having to do with the operation of the SGR system, in particular having to do with some time lags associated with the calculations in the system, and the second having to do with correction of estimates that HCFA uses when they implement the SGR system.

If we turn first to the changes in use of needed services, recall that when we've talked about the SGR system in the past, we've noted the importance of it, that this is used to make annual updates in physician payment rates. And the sustainable growth rate itself is really a central part of the system. It takes into consideration four factors, changes in physicians' fees, changes in Medicare fee-for-service enrollment, growth in real GDP per capita, and changes in spending due to law and regulations.

With 1997 spending as a baseline, the SGR is used to project forward spending and to identify a "allowed level" of spending for physician services. So this is a key part of the system.

In particular, this factor having to do with real GDP per capita in the SGR is important in that it's what allows spending to grow to accommodate changes in beneficiary use of needed services, changes in medical technology, changes in medical practices, and so on.

At previous meetings, the commission has expressed the desire to adopt a recommendation on that factor and there's been some discussion of maybe changing the factor to be real GDP per capital plus a percentage point or two to accommodate changes in medical practice.

So what I have discussed in the paper that we sent you for the meeting was a couple of different options for what that recommendation might be like. The options, as I see it, and I can go into this in a little more detail in a second, would be to just make no recommendation at this time. Another option is to make that real GDP per capita plus a percentage point or two. And the third option would be to build into the SGR a factor for changes in the composition in the fee-for-service enrollment.

A reason for making no recommendation at this time would be that growth in beneficiary use of services has slowed in recent years. This graph shows changes in growth in the volume and intensity of physician services per beneficiary starting in 1995 and going through 1996. As you can see, during the earlier years, from '85 through '91, volume per beneficiary was quite a bit different from growth in real GDP per capita. The average in volume for physician services was about 7 percent over that period.

But since then we've seen some moderation in the growth in use of physician services. From '92 through '96, the average was only 2 percent per year. For that same more recent period, real GDP per capita was in the neighborhood of about 1.3 percent. So an argument could be made that volume growth has slowed some, has become closer to real GDP per capita, and maybe no recommendation for a change in the SGR is needed at this time.

The other option would be to make that recommendation of real GDP per capita plus a percentage point or two. A rationale for that kind of a recommendation would draw upon projections made by HCFA actuaries which show that this slow down in volume growth is transitory, that starting in about the year 2001 when we anticipate some increase in the volume of physician services per beneficiary.

The range of HCFA actuary projections is on the order of 1.5 percent up to about 4 percent and an average
of 3.5 to 4 percent. So there is some difference between what real GDP per capita is estimated to be and what HCFA actuaries are saying volume growth is expected to be in the fairly near future, starting in the year 2001.

DR. LONG: Kevin, is this the same phenomenon
that has led to -- was it the CBO projection that health care is going to be an increasing percentage of GDP between here and 2008?

DR. WILENSKY: No, that's HCFA.

DR. LONG: Was that HCFA. But the notion that it's health care -- unlike the last five years where it's been basically flat as a percentage -- will resume capturing share, if you would, and be a larger proportion of what, on average, we're all consuming?

DR. HAYES: That's right. They're expecting that a number of factors will drive these increases. They have to do with things like the aging of the population, diffusion of medical technology, changes in medical practices, and so on.

DR. LONG: Is it also our assumption that Medicare will be a growing percentage, either of the overall economy or of the health sector?

DR. HAYES: I think you could say that. Certainly if we're expecting the volume and intensity of physician services to grow, it's going to grow as -- Medicare expenditures are going to grow, they're going to be an increasing part of the economy, yes. All other things being equal.

A third option for a commission recommendation would be to build into the SGR some factor for changes in the composition of fee-for-service enrollment. There was a brief discussion at the last meeting about accounting for changes in the age of beneficiaries, age distribution of beneficiaries. I took that idea another step further and said that we could also account for changes in sex and mortality rates, and adjust the SGR accordingly.

So those are just some thoughts. For the January meeting, I would anticipate that we would have some data for you all to look at that would show how the distribution of the beneficiary population has been changing over time with respect to age, sex and mortality rates.

DR. WILENSKY: Kevin, you don't mean these necessarily as mutually exclusive? For example, the second and third couldn't certainly be done. I mean, I think it's, in my mind, pretty easy to justify the third. And then the second is only whether we want to make a statement in principle or wait until we have a particular time. But I don't regard those as mutually exclusive.

DR. LEWERS: Talking about the second and third recommendation?

DR. WILENSKY: Yes.

MR. MacBAIN: Just a question on that. You said that the second recommendation was based on HCFA actuaries' projections of cost trends.

DR. WILENSKY: Wait a minute, that's incorrect. At least what Hugh was citing was a study that was done by researchers in the actuary's office. This is not an actuarial projection. This has not been an actuarial study in the nature of what we do --

MR. MacBAIN: What was Kevin citing?

DR. HAYES: What I was citing was projections in the Part B trustees report.

MR. MacBAIN: My question about that was, were those projections based on projected changes in the age, sex, other characteristics of the fee-for-service population. If so, are these last two recommendations essentially the same?

DR. CURRERI: I think they're different.

DR. NEWHOUSE: ... suggests that that's right.

DR. CURRERI: I think the second recommendation was related to a plus 1 percent, not for increasing intensity of service or anything, but to include increased costs associated with advances in scientific technology.

DR. NEWHOUSE: It's the S&TA. That's the old PPRC view but what Kevin is citing as the HCFA --

DR. CURRERI: No, but what Kevin is citing really relates to number three, so I think that they're mutually exclusive and I, for one, would be --

MR. MacBAIN: No.

DR. CURRERI: They're not mutually exclusive, but they cover different aspects of the increase in cost, I should put it that way.

I really support both two and three and I think both two and three we should make. I would change the first recommendation. I don't think medical capabilities is what we mean at the end of

that sentence. To some extent it's medical capabilities but I really look at it as advancement in medical science or scientific technology or something like that.

DR. WILENSKY: Cost increase.

DR. CURRERI: Cost increase associated with scientific advancement, because medical capabilities could bring in a whole host of things that I don't think we're talking about.

DR. NEWHOUSE: I like medical capabilities because technology, to most people in every language, implies like machines.

DR. CURRERI: How about saying both, improvement in medical capability and advancement in scientific technology, or something like that? Just to differentiate it for the difference in demographics, which we talk about in the third one.

DR. WILENSKY: Let me make the suggestion, because I guess I think about them differently. I would like to see what we have as number three first, before what we have now as number two, on the grounds that that is a clearer to justify rationale. So that making adjustments for demographic changes and for what happens within the fee-for-service world I think is something -- whatever the Congress' position on allowing for more than the growth of the economy, you would justify that this is a more accurate reflection of just using sort of a blanket SGR number.

And then as a second recommendation, and I don't know whether we want to use something like 1 or 2 percent, but to allow for a growth that accommodates the effects of growth in medical capability, cost increasing medical capabilities, and scientific technology. Whether we say 1 or 2 percent or just to indicate that we want to allow this above the growth in the economy would be the second measure.

Again, it's a little harder to say exactly what the right number is, but to allow for it to be in there --

DR. CURRERI: I accept that, and you're just putting the priorities a little different, and I think that's fine.

I also am in agreement to take out the 1 or 2 percent. It sounds like we don't really know, and we don't.

DR. WILENSKY: And we don't. We don't have any justification for that.

DR. CURRERI: So I think we ought to just say some increased amount to account for.

DR. LEWERS: We could pick one.

DR. WILENSKY: Said with no bias whatsoever.

DR. LEWERS: No bias. He said three. He gave you three reasons why. I'm willing to go with two, it's right in the middle.

[Laughter.]

DR. LEWERS: But Kevin's going to come back, you said, on the composition of fee-for-service. You're coming back with more data?

DR. HAYES: That's right.

DR. WILENSKY: Right.

DR. KEMPER: So physician expenditures are going to be growing faster than GDP under the set of recommendations?

DR. WILENSKY: Yes, without some specificity, on the grounds that the mix would justify that, and then to allow for some, as yet unspecified growth to reflect capability, medical capability.

DR. KEMPER: But that wouldn't be true of hospital and outpatient and other --

DR. WILENSKY: We do. We have it in -- that's what S&TA is in the hospital. It allows for cost increasing technologies. We don't have it here. In fact, what we have in the physician world is much stricter.

DR. KEMPER: But the other adjustments in the hospital side take it down below the rate of growth of GDP.

MR. MacBAIN: It's below a different market basket.

DR. WILENSKY: It's a question of below -- I mean, it takes a lot of factors into account in addition to this, but it allows explicitly for cost increasing technologies.

DR. NEWHOUSE: Other things take this below like the change in fee-for-service enrollment.

MR. GUTERMAN: But also we're talking about a per case update on the hospital side and here we're talking about public expenditures, which is very different.

DR. HAYES: The SGR for fiscal year 1999 is minus 0.3 percent.

MR. MacBAIN: Now in an ideal world we're talking about all these SGRs coming together as a single number, which would eliminate these kinds of concerns.

DR. NEWHOUSE: But we don't really have the SGR on the inpatient side because admissions are free to vary.

DR. WILENSKY: Right. This really puts the whole ultimate hold then.

DR. NEWHOUSE: Are you going to talk about your other recommendations?

DR. HAYES: Yes.

DR. NEWHOUSE: But the way, I think you can justify the GDP plus based on the historical data on that chart.

DR. HAYES: That the average is 2 percent?

DR. NEWHOUSE: You don't have to pick a number, but it's greater than zero.

DR. WILENSKY: To keep it at zero would have a big bite over what we have observed.

DR. NEWHOUSE: By the way, also for other countries.

MR. MacBAIN: People used to die cheaply, live expensively.

DR. NEWHOUSE: General medical expenditures tend to outrun GDP. I don't have a calculation, just the position.

DR. HAYES: We move on now to the two technical issues having to do with the operation of the SGR system. The first of them has to do with time lags between measurement periods associated with SGR system calculations. I'll try my best to go through these and explain what's going on here.

The SGR system involves a series of calculations and there was an appendix in the paper that I sent you that explained what they're like. The mismatches in time periods that we're dealing with here have to do with three things. First, the SGR itself, which is calculated on a fiscal year basis, fiscal year ending on September 30th.

The SGR, in turn, is used to identify allowed charges, we talked about it a moment ago. Allowed charges or allowed expenditures are compared with actual expenditures to calculate something called an update adjustment factor. That is calculated on the basis of a year ending on March 31st. All of this feeds into a conversion factor update which is applicable to a calendar year.

In a notice that HCFA published in the Federal Register in early November identifying the sustainable growth rate for fiscal year 1999, they pointed out that mismatches in time in their simulations was shown to lead to what they called oscillation in conversion factor updates, meaning that there would be the sharp swings in the updates over time from the maximum update, which is MEI plus 3 percentage points, and the minimum update which is MEI minus 7 percentage points. And they viewed this, rightfully so I think, as a problem.

So to address this issue we obtained data from HCFA, quarterly data from HCFA, and essentially replicated the simulations that they did and found the same problem. Maybe we'll look at this next slide, which illustrates.

The dark bars here show the effect of the time lags. If you look out in the years 2000 and beyond you begin to see, starting in about the year 2004, these sharp swings in the annual updates in the conversion factor.

DR. CURRERI: Kevin, what are we looking at here? Is this the SGR or is this market --

DR. HAYES: This is the update itself. So you take the SGR, go through the rest of the calculations, come up with the update adjustment factor, add that to the Medicare economic index.

DR. CURRERI: So what would happen in year 2004 it would be cut off at 3 percent; is that correct? And then that would be carried on to the next year?

DR. HAYES: No, the maximum in these simulations is 5.3 percent in the conversion factor update.

DR. CURRERI: That's the medical market?

DR. HAYES: That's the MEI plus this update adjustment factor, right. So that would continue on for a few years and then, due to the time lags involved here, strictly an artifact of the way the data are used in the calculations and the time periods involved, we see this sharp drop in the updates starting in the year 2007 and continuing on at least through 2009.

So if one were to put all of the calculations on a calendar year basis, eliminate the mismatches in time periods, then it appears in the limited simulation work we've done so far that that addresses the problem, that this oscillation problem goes away. I want to do some more kind of sensitivity analyses to see what happens under different assumptions of volume intensity growth per year, but at least for now it appears that this is a way to address the problem.

DR. CURRERI: Is the diametrically opposite results seen in year 2000 due to the fact that there's going to be the staggered time periods now?

DR. HAYES: The staggered time period problem exists now and what happens, in effect, is that the mismatches kind of develop into a cumulative problem. They start to add on to each other and then you start to get these wide swings in the conversion factor updates.

DR. CURRERI: So even if you started right now, you could only correct it in the year 2002, the oscillations?

DR. HAYES: This would require legislation and depending upon when Congress acts, the change could be implemented for the year 2000 conversion factor update.

DR. NEWHOUSE: Kevin, do we have any suggestions on the transition?

DR. HAYES: I haven't thought that far. I had always thought that this would be implemented within a year of Congressional action.

DR. NEWHOUSE: When you go to the calendar year basis, you've got some partial years or some problem, don't you?

DR. HAYES: You would take the actual expenditures for the most recent calendar year that you have and project those forward and use the SGR that's in hand and I believe it could be implemented without a transition.

DR. LEWERS: Say that again. It could be implemented without transition?

DR. HAYES: Without a transition.

DR. NEWHOUSE: I didn't mean a transition in a kind of staggered over three years kind of sense. I meant you've got differing time periods now, one ends in March. So I've either got a 21-month period, it seems like, or a nine-month period in there that I've got to handle.

DR. HAYES: What I had anticipated was, and

this is probably working out in some more detail, that where the calculation of the update adjustment factors for a year that ends on March 31st, we would just go back to the most recent calendar year ending, which would be the previous December 31st. That would establish a level of actual expenditures.

DR. NEWHOUSE: Are you sure that wouldn't oscillate? I thought the whole idea was to get these things contemporaneous.

DR. HAYES: There's still a need to make estimates of what actual expenditures are going to be. Right now we're toting up actual expenditures through a year ending on March 31st for a calendar year that starts the following January 1st. The change that's necessary is to stop the counting of actual expenditures at the previous December
the 31st and make an estimate of what actual expenditures are going to be during year one and the year in which the update is actually going to be implemented.

DR. NEWHOUSE: That's right. And then adjust for the errors, as you said. That's right. All right.

MR. MacBAIN: Do you have any sense of the impact of using a cumulative factor rather than a point figure each year? It seems to me after a relatively small number of years the year-to-year changes in the GDP per capita figure are going to have almost no impact on the SGR index.

DR. HAYES: What time is it?

[Laughter.]

MR. MacBAIN: If you've got a cumulative index, after nine years the 10th year will have a one-tenth impact, one-tenth of the impact that the first year had on what the index is, whatever the change is. As this accumulates each year we'll have less and less of an impact on what the total value of the SGR -- what that cumulative number is.

I don't know if that's good or bad.

DR. ROSS: Are you saying the floor is stable?

MR. MacBAIN: No, it's just if the notion is that each year this will change to reflect a gap between growth in medical expenses versus change in GDP per capita, after a number of years one year's change doesn't have much impact.

DR. KEMPER: Except that you've adjusted each year along the way to try to be close to that.

MR. MacBAIN: Yes, it should equal the total.

DR. NEWHOUSE: That's a different issue. This oscillation is because --

MR. MacBAIN: I thought we were off of this. I thought we all agreed with this.

DR. NEWHOUSE: This is the corrected annually for errors?

MR. MacBAIN: I'm assuming it's corrected annually for errors but after about 10 years you've got a large number that is the cumulative total of all of this stuff. And so an annual change is going to be a very small percent of this large cumulative total.

DR. NEWHOUSE: Yes, but you've been correctly presumably as you went along, so the latest year's error is still what's dominating that calculation.

DR. LONG: What you accumulate is the differential that presumably you've narrowed by these adjustments. You take that differential off of next year's proposed --

MR. MacBAIN: Is it the differential that's accumulated? That will do it, so it should be staying around zero.

DR. CURRERI: But it may not be a total correction because you've got limits of plus three percent and minus seven percent. So if there are wide oscillations, particularly if they're all in one direction, there is a potential for getting a cumulative effect, simply because you've got these outside bars.

DR. NEWHOUSE: But you'll still be correcting as you go along.

DR. CURRERI: Yes, you'll still be correcting, but only to certain limits. It depends how big the oscillations are.

DR. NEWHOUSE: But then you'll pick it up the following year.

DR. LEWERS: You're talking about -- now you've moved on to the correction per annual, right?

DR. NEWHOUSE: Yes.

DR. LEWERS: But are we correcting for this year? Because if you don't correct for this year, where the estimates are off, the time lag is off, then you have a loss which is going to occur every year from here on out even when you do the correction. So shouldn't we correct for this year? But we don't say that.

DR. HAYES: My response to that would be that because the system is cumulative, we will capture any error in the system.

DR. LEWERS: When?

DR. NEWHOUSE: Next year, unless you hit these limits.

DR. WILENSKY: As soon as you start it.

DR. NEWHOUSE: If you look at it his formula in Appendix A here, and then you look at your allowed spending for some period of time, and then you look at your actual spending for all periods of time up to that year.

DR. WILENSKY: So unless you hit one of the boundaries, as soon as you start this, you'll pick up this year's error. And if you did hit the boundary, you'd do it in the next year.

DR. NEWHOUSE: Another way to say this is if you made no error in '97 and '98 --

DR. WILENSKY: You don't lose it, you just lose it for this year.

DR. LEWERS: That's what I'm saying is, you lose it for this year. When you know you're going to lose it for this year, when you know the factors are not correct, it's going to be lost for a year.

DR. WILENSKY: For a year. It will come back in.

DR. NEWHOUSE: For a year. It will come back.

DR. LEWERS: You won't make it up.

DR. WILENSKY: You will make it up.

DR. LEWERS: You will?

DR. NEWHOUSE: You will. Look at this equation.

DR. LEWERS: I'm trying to listen at the same time but that's my problem.

DR. NEWHOUSE: So if you walk through this and you say allowed spending '97 through '99, and then you have actual spending '97-'98. Now suppose you made no errors so allowed equaled actual. Then a factor is just one. So if you make errors then you pick them up in this subtraction, in the numerator there.

DR. CURRERI: But I think there's an error in the formula because the formula can't be '97 through '99, which is three years, and subtracting actual --

DR. NEWHOUSE: No, there's no error. It's supposed to be.

DR. LONG: It's variation in the tail as a percentage of what's allowed. It's the prior tail's variation cumulative.

DR. NEWHOUSE: If there's no error in the prior years and actual equals allowed then that factor is one, which it's supposed to be.

DR. WILENSKY: We can continue this discussion later. It might look different over a glass of wine.

DR. LEWERS: Sounds like a dinner discussion.

DR. WILENSKY: Right.

DR. HAYES: We can go on to the correction of estimates issue, just briefly. Also in the notice for the fiscal year '99 SGR, HCFA drew attention to a problem with correction of estimates. The sustainable growth rate itself, if you'll recall, is made up of four factors, fee increases, change in fee-for-service enrollment, growth in real GDP per capita and changes in expenditures due to law and regulations. Fine.

All of those are estimates prepared by HCFA and there's a possibility, of course, that there will be errors in those estimates. HCFA believes that it should have the ability, once better data become available, to correct any errors in the estimates that are used in the SGR system.

But they have found that, in review of the law, that they do not have authority to do so at this time and they feel that it's important to have that authority. A recommendation the commission could make would be that indeed HCFA should have that authority.

I'll give you more precise language for the January meeting, but that's the basic idea.

DR. WILENSKY: Very interesting on this oscillation. I don't think that was anything that those of us would have guessed was going on.

DR. LONG: Why didn't that happen to the VPS?

DR. NEWHOUSE: It did. It just hadn't hit yet. It was about to hit when we went to SGR.

DR. WILENSKY: And we did have the other problem that we had no cumulative effect.

Before we go back to Jim on the ASC, why don't we open this up for public comment on the issues that we have discussed this far and then we'll go back to the ASC for a bit.

MS. McELRATH: I'm Sharon McElrath with the AMA. We're very happy to see you make a number of those changes. Those are things that we had requested in a letter.

There was one other thing and that involved when you had the discussion today about the product change or the through-put or the productivity, or whatever it was. There seemed to be an assumption that where it was a site of service change that Medicare would automatically be paying for that change.

Where there is an SGR, and this would be for the physician services, and ultimately it could be for the hospital outpatient department services as well, that wouldn't necessarily be the case because if the increases in services that are triggered in physician's offices due to people being put out of the hospital with shorter lengths of stay increases the volume, the physicians may be penalized with a lower update.

In addition to that, there is a budget neutrality requirement that says that the physician expenditures cannot increase by more than $20 million a year. So that what you end up getting is that, to the degree that the increases are occurring in physicians' offices you take it away from other physicians. Again, to some extent, that would be true with hospital outpatient, as well.

We also would like to see you do one other thing, which is to start previewing the physician updates. I mean, at this point, you spend hours discussing what the hospital update is likely to be, whether it is the right amount or not. The way the law is set up now, there is no projection of what the physician increase is going to be. In effect, neither Congress nor the commission ever really even is asking what will it be.

It's like putting something on cruise control but not letting the driver override the cruise control when you need to speed up or slow down to prevent an accident.

Just one other thing on the oscillations, we're happy to see you do that. We wonder if, depending on further sensitivity analysis, whether you might want to reduce that corridor so that a minus seven -- I mean, it's sort of hard to imagine Congress ever even considering hospital or home health or nursing home, any other sector, having a minus 5 percent as your update.

DR. WILENSKY: The hospitals certainly...

MS. COYLE: Let me address that.

[Laughter.]

MS. COYLE: Mercifully, I'll only comment on two of the last three segments, but I will drag you back to the first two with a theme line being uncertainty.

With regard to the discussions on the hospital update recommendation, and I think to Dr. Curreri's point, I think the question you raised was how important is all of this information and how will it be used.

While the Congress has already legislated update factors through the year 2002, I would like to remind this commission that your work is extremely important. In fact, in your March report, this item may be one of the most important items that Congress takes a look at.

The issue of hospital update factors every year is back on the table. Especially as Congress is looking to finance potential changes in the Medicare program I believe it will be back on the table. And Congress looks to the recommendations of this commission. Your recommendations are highly influential so it is extremely important.

Having said that, I have to admit I followed Jack Ashby's work on the issue of product, productivity or through-put for some time. In true confessions, I still can't get my own brain about it. I don't know about you but it's extremely complex. I think it is perhaps the fuzziest of all of the components in the hospital update framework.

Yet if you take a look at last year's update framework, it is also the component that has the largest implication for what the update ultimately is. In last year's recommendation it could have moved the update recommendation some 3.7 percentage points, which in one year alone is $3 billion.

So your recommendation again is extremely important. I would urge significant caution in terms of how much you put into the product/productivity/through-pout adjustment because of the huge variability that's involved.

With regard to the formula, just a couple of issues and back to one of the slides here. I think a couple of issues, we're adding things like days per discharge plus service per days plus inputs per services to get inputs per discharges. My sense is it's multiplicative not additive.

DR. NEWHOUSE: It's additive in changes.

MS. COYLE: And the issue of equal weights here. I'm just not sure I understand that. The potential for double counting has been mentioned. The issue of what it is we're really measuring I think has been raised. So all of these things, I think, would suggest that the commission may want to proceed with some caution on this.

A final note on the update factor, the concept of a cumulative site of service care substitution, the SOCS, the idea of potentially doing a retroactive adjustment on the order of magnitude of 9 percent in what is the Medicare prospective payment system, that is a retrospective adjustment in a prospective payment system, I guess personally I feel is anathema to the whole concept and again, would urge caution.

Let me shift gears to ambulatory care, and again the theme of uncertainty. What I heard at least is a lot of uncertainty in terms of understanding around some of these issues, and in terms of some of the research that we may yet need to pursue.

The concern was raised about the hypothetical ability to provide services across settings. I think the emphasis again on hypothetical, I think Jim's own data suggested that that, in fact, wasn't the case. I think it is important to monitor but it's not yet an issue.

On the outpatient volume control issue, I really urge caution on this one. That is that this is not really a volume control. It is a spending, an aggregate spending, control. I think we may mislead people to think that it's a volume control. It's just a spending target, a spending control mechanism. It is

a dull public policy tool. It is one that will sweep in not only unnecessary services, but also necessary services, estimating errors, increases in technology, new drug development, that may move services into the outpatient setting.

The real question here is what growth is clinically appropriate and what growth isn't clinically appropriate and I think there's still a lot of room for work here.

I would strongly urge the commission to reject an outpatient spending cap, it's not a volume cap, and at a minimum encourage you to do some more work in research before making a decision.

In terms of the data itself, and I think Jim mentioned this, there are large reductions, large redistributions that are to be experienced in the hospital outpatient department setting. Some 7 to 9 percent reductions for rural hospitals, 30 percent for cancer facilities, 24 percent for rehabilitation hospitals. And we don't know why.

That is distressing. I think Jim mentioned, if you're in for a penny you're in for a pound -- is that how that went? You're in for a penny, you're in for a pound. Maybe we're mixing metaphors. Having said that, I think it's also some questionable sets of information on which to be making some very important policy decisions when it comes to outpatient spending.

Two last points. Medicare beneficiary coinsurance and the commission's desire to see that happen more quickly. I think there was an exchange between Gail and Bill about whether or not that would be funded by the program or funded by hospitals. I would strongly encourage the commission to put in the fact that you believe it should be funded by the program, in part because in the proposed outpatient rule HCFA is, in fact, suggesting it should be funded by hospitals for the first year. We don't think they have the authority to do that, but to be clear would be very helpful.

And finally, the idea of a Medicare-wide SGR. In the same respect that an outpatient volume cap isn't a volume cap, it's just a spending growth. To go Medicare-wide really is just setting a global spending target for Medicare and I would just urge caution as you proceed.

Thanks.

DR. WILENSKY: That is what we were suggesting. But we agree that it shouldn't be called volume because it is spending.

DR. CASEY: May I make a comment on productivity? I'm Don Casey from the Maryland Quality Improvement Organization.

I appreciate the discussion about this and I want to pose some rhetorical questions to the commission. Because when I heard the term productivity it instantly raised the question in my mind as to what, in fact, the product was. I think you've debated that a bit. But I suppose that how you define product depends on how you define an episode of care through the system. Sorry about that phrase, but I think you know what I mean.

I raise the question as to whether you can define the product in terms of outcome and quality and therein raises the age-old question of how you define risk. But assuming you can, it seems as though reducing variations in care that have been well documented would seem to be most important and logical targets to focus on to improve productivity.

I would suggest, and I hope you agree with me, that many gains in efficiency would likely cost little if anything. So that's just something to think about. I think it's worthwhile going through with this productivity issue but I think you need to figure out what the product is first.

DR. WILENSKY: Jim?

DR. MATHEWS: A minute ago I was complaining that three weeks was a quick turnaround to be up here.

This is a work in progress and it won't have any direct bearing on any particular recommendation that you might make. However, I believe it does shed light on the issue of consistency

of payment across ambulatory settings in general, and it might be something to keep in the back of your mind as you think about these questions.

Throughout the commission's discussion of ambulatory care of the last year one fundamental tenet of this payment policy has emerged which is consistency of payment across settings. If we've interpreted this correctly it means that all else equal Medicare should pay the same amount for the same service, regardless of the setting in which it's provided. It stands in profound contrast to the current situation in which payment for the same service varies depending on where it's provided.

But we asked ourselves what actually constitutes the same service. Is a chest x-ray always a chest x-ray, to pick up on Jack Rowe's previous example? If not, how is it different? What makes it different? And what accounts for its variation.

The questions are important because if the chest x-ray is qualitatively different situationally should its payment also be different? This gets to the core of some of the things that we talked about earlier. Do you vary payment by some criteria in order to achieve certain policy goals?

For example, if ambulatory surgical centers can provide a high quality cataract surgery for 20 percent less than hospital outpatient departments, the program has a vested interest in paying that reduced rate. The question again, though, is the surgery the same?

So throughout the summer and fall of this year we've developed an analysis to explore some of these questions, approaching them from two different directions. First was looking at the facilities that provide the services and, by inference, the populations that specific facilities or specific classes of facilities treat. Second, we planned to look at the beneficiaries themselves, where they get their services, and other beneficiary characteristics.

We've got some preliminary results of the first set of questions to present today, specifically the facility focused analysis.

We wanted to look at the relationships between ASCs and hospital outpatient departments, particularly the extent to which ASCs represent a true lower cost alternative to the hospital outpatient setting for the majority of beneficiaries and services. And if so, what effect their presence or absence in given market areas had on hospitals' provision of these same services.

For example, did ASCs have any impact on hospitals' charges? You could hypothesize that if ASCs were competing with outpatient departments to provide these services, hospitals might be expected to hold the line on their charges because this is what the beneficiary feels most directly.

Similarly, did ASCs have any impact on hospital outpatient volume? Again, if you assume that there is a uniform total rate of growth in the provision of these services, the ASCs might be picking up larger and larger market share in those areas in which they were present.

We first looked at the geographic distribution of ASCs. We want to focus here on 1991 and 1996 for the present analysis. I have to admit it's because of data constraints, when we go back earlier we also tried to put in a third point here in 1988 and found that the claims level data were somewhat irregular.

Anyway, between 1991 and 1996 the number of ASCs grew from about 1,380 to 2,264, an annual growth rate of 17 percent and an absolute rate of 63 percent increase. During the same period of time the number of hospitals providing outpatient services declined steadily. However, this ASC growth that we've seen has not been uniform in all geographic areas.

For example, in 1991 ASCs were located in 533 counties in the U.S., 89 percent of which were in urban areas. What this map shows is those counties with ASCs. The lighter shaded represents counties with one to five ASCs and the darker ones are those with greater than five. This is in 1991.

By 1996, ASCs were present in 637 counties or 20 percent more counties than in 1991. During this same time, as I mentioned earlier, the number of facilities increased by over 60 percent so the

data suggests that ASCs expanded mostly where they existed previously, rather than into new a areas. So if you look at that map up there, there is still a lot of white space where there are no ASCs.

DR. CURRERI: Is there any problem with this data related to the semantics of what you call yourself? I know that, for instance, in some of these counties that are white, that presumably have no ASCs, that there are specific ASCs related just to ophthalmology. Are they classified ASCs if they are state ASCs but only do ophthalmological procedures?

DR. MATHEWS: What I'm glossing as ASCs here are those certified as such by HCFA. There are a separate set of requirements that a facility has to go through.

DR. CURRERI: So they have to be pretty broad ranged then, as well?

DR. MATHEWS: Well, as we get through this data, you'll see that that's not necessarily the case. We'll keep working on that.

So the point here is that ASCs primarily expanded in areas where they already existed in 1991.

We found that ASCs were not only limited in their distribution among MSAs, but also within MSAs. For example, in Baltimore we found that in 1991 most ASCs were not located in the central urban area but instead tended to be focused in more suburban locations while hospitals were more likely to be in the urban core.

DR. LONG: Are those zip codes?

DR. MATHEWS: Yes, these are zip codes within the Baltimore MSA. Here's the same map for 1996.

DR. LEWERS: Did you outline Talbot County for any specific reason?

DR. MATHEWS: No. This is a relatively new mapping software we've been playing around with. I would advise you not to stare too long at this map.

DR. LAVE: Where's Baltimore?

DR. LEWERS: In the middle of that mess.

DR. MATHEWS: Yes, in the very center. If you see that rectangular cutout, that's DC at the bottom. If you go at about a 45 degree angle up from there. There's the Inner Harbor, there's Baltimore.

DR. LAVE: So it has no ASCs; is that correct?

DR. MATHEWS: In 1996, I believe there was some presence of ASCs but earlier there were not.

This pattern continued in 1996 and we found similar distributions in Los Angeles and Phoenix which were also among the MSAs with the highest numbers of ASCs in both years. Again, you see more facilities in the same areas where they existed previously.

So in short, ASCs are generally not located in rural areas. They tend to be located in high population density areas, but even here their distribution isn't uniform and not all urban beneficiaries may have access to these facilities. Further, the data suggests that ASCs are not likely to expand into new areas, especially given the proposed reductions in their payments.

The next part of the analysis was to examine the services that ASCs actually provide. We found that while ASCS were allowed to perform some 2,500 discretely coded for Medicare beneficiaries, in practice they actually provide very few of these. The 20 highest volume procedures accounted for about 80 percent of ASC program payments and utilization in 1996. The top 100 procedures accounted for about 90 percent of payments and utilization. There were 1,000 procedures on the ASC list for which there was no Medicare utilization in 1996.

MR. JOHNSON: Would those procedures be provided in a hospital outpatient department?

DR. MATHEWS: I believe they are. I couldn't answer for every one of them, but I believe there is hospital outpatient volume in most of these cases.

DR. LAVE: Do you have a comparable chart for hospital outpatient departments?

DR. MATHEWS: We published one in the June report of last year. You remember that.

DR. LAVE: Every item on it, all 1,020.

MR. JOHNSON: I just have a question, going back to our earlier discussions on this where we talked about using ICD-9 codes versus -- what's the other terminology?

DR. MATHEWS: The HCPCs.

MR. JOHNSON: The fact is though that if we extend it into the hospital environment, you'd in fact be coding or adjusting procedures that aren't even done at an ASC?

DR. MATHEWS: I don't follow the question.

DR. CURRERI: They would have HCPCs that aren't offered at an ASC.

DR. MATHEWS: Yes, ASCs provide a limited subset of --

MR. JOHNSON: I guess that's my concern, because there's a lot of cost data, whether economists like it or not, in the hospital cost structure and in specifically the outpatient department. So given our recommendation that we're making to HCFA, my only concern is you're going to translate in a bunch of areas where they don't even do procedures and try and decide a rate where they don't do procedures on a rate on a hospital outpatient department. I just don't know how that works.

There's 1,000 things that aren't even done in an ASC. How the hell are you going to fairly calculate the rates of what they should be?

DR. MATHEWS: I feel like I'm batting 1.000 today because that is exactly the point that I hoped you would think about. I'm not going to answer it, but I hope you will think about it as we work through this.

MR. JOHNSON: I'll be up all night calling you every hour while I think about it.

But given the recommendation we made, retrospection is always perfect. It doesn't seem to be a very sound recommendation. I'll leave that for my fellow commissions, and let them sleep on it.

DR. LAVE: Could I ask a question? I apologize for missing a lot of this day, so this may have been discussed when you talked about this earlier, I assume you talked about it earlier.

There were really two things that we talked about, one of which was consistency. That is, sort of the same labeling in every place, so that in fact we could track what was going on and make sure that we could compare. I wasn't sure that we had actually recommended identical payments. I don't think identical payments and consistency are the same thing.

DR. WILENSKY: That is correct. We have distinctly not recommended identical payments. I just want to alert the commissioners that one of the discussions I'd like to raise at the beginning of our dinner hour is the tensions between going toward consistent payments across ambulatory care versus looking at the hospital as a more integral unit, and to just start a discussion about that.

This is not something we're going to resolve quickly but I'm feeling torn by the directions of this morning's discussion when we were talking about going through the charts that Stuart had passed out, in terms of looking at inpatient and total margins and PPS versus totals and looking at the hospital as an institution versus consistency across other institutions.

We can have this discussion but I would like to continue it early in the evening, also.

DR. KEMPER: Gail, I'm just confused by your statement that we haven't recommended it. I thought the thrust of equal payments -- I have to admit it's somewhat ambiguously worded but payment amounts under both the hospital OPD and ASC should be evaluated concomitant with payments for services provided in physicians' offices to ensure that unwarranted financial incentives are not provided.

DR. WILENSKY: Exactly, and we mean that. But we also talked about the fact that if you have different sets of comorbidities, if you're in a single sole community hospital, that those would be

mitigating factors. So I think what we have said is that we want to look at instances when we have other factors or differential payments, to be sure they're present for a reason, as opposed to just going down separate tracks which might end up providing very different payments for what is either exactly the same or essentially the same service.

I think we have opened up a number of cases where we believe it would be appropriate and justified to have a different dollar amount, but we want to do that in a proactive way as opposed to just doing it separately, if I haven't misinterpreted what we're --

MR. MacBAIN: I think the issue is incentives, which isn't necessarily the same as the price.

DR. KEMPER: It's not at all clear to me what that recommendation means then.

DR. WILENSKY: Again, I think that up until now these have been developed independently.

DR. NEWHOUSE: Which recommendation?

DR. WILENSKY: The one you just read.

DR. KEMPER: The one I just read.

DR. WILENSKY: I think the one you just read allows for some different absolute payments if there are specific reasons why you think that would be appropriate.

DR. MATHEWS: That was my intention in using that language.

DR. NEWHOUSE: You mean the warranted financial incentives one?

DR. KEMPER: Right. I don't know if that means --

DR. NEWHOUSE: It doesn't imply identical payments.

DR. NEWHOUSE: No, it doesn't imply identical payments. You don't know what marginal costs are.

DR. KEMPER: So what does it mean?

DR. WILENSKY: It means you want to be explicit about the kinds of differences that you allow.

DR. NEWHOUSE: It means the difference between what you're paying and marginal intent, and what you pay and marginal costs isn't greatly disparate across the places where there are substitution possibilities.

DR. KEMPER: Say that again.

DR. NEWHOUSE: Where you can substitute across sites of service, the difference between what you pay and the marginal costs wouldn't be greatly disparate.

DR. KEMPER: So that means different payment rates but consistent differences between --

DR. NEWHOUSE: Again, we don't know what marginal costs really are, I would say, and they're going to vary from facility to facility. I think the general intent is to say we're concerned about site of service selection on the basis of financial incentives.

DR. KEMPER: That's clear. This just isn't very helpful on what to do.

DR. WILENSKY: Because it's trying to lay out a general principle as opposed to operationally specify how to make these payments.

MR. MacBAIN: I think the point is we know what we want but we don't know what to do.

[Laughter.]

MR. JOHNSON: But are we saying this would be limited to a certain number of procedures that could be done anywhere? Or that any procedure has the ability to be done somewhere outside a hospital outpatient department, when we just heard 1,000 of them aren't even done outside a hospital outpatient department?

DR. NEWHOUSE: I guess we're concerned about unwarranted financial incentives anywhere. I mean, if paid $10,000 to remove a toenail, we'd be concerned about that.

MR. JOHNSON: But the data has shown, I thought, that that's not happening. There isn't a substitution --

DR. CURRERI: But I think you have to be careful. That doesn't mean 1,000 are done in the hospital outpatient department and not done in the ambulatory surgical centers. It may be that 1,000 are done in offices and not done in ambulatory surgical centers.

DR. MATHEWS: Right.

DR. WILENSKY: Clearly, some of the ones that are on that list, the endoscopy, the gastroenterology procedures, I mean those are done in all of the settings.

MR. JOHNSON: I understand that. But there are some that are done in outpatient --

DR. WILENSKY: But cataracts are almost exclusively done -- well, even that isn't --

DR. CURRERI: Like all the dermatological procedures are, by and large, done in offices because it's clearly the most convenient and inexpensive way to do it. And that's a huge volume of procedures.

DR. WILENSKY: It is also, I think, Spence, to say that what has existed up until 1996 or 1997, the last time we have our data, and what may exist in the future, both with the change in payment rates going in effect and with the changing technology that continues, may make something which hasn't been observed to be a problem in the '90s a problem in the next five or 10 years because clearly moving to allowing for more sites to do specific procedure rather than fewer sites. If you look at the direction, that's clearly what's going on.

So it's to make sure that if we have different financial payments that there's a rationale for them. I think practically we'd probably say if we know the procedures for which substitution is a more immediate problem, that we focus there first. But we're not suggesting we only look at the places that are a problem now.

MR. JOHNSON: But just to try and make my point and then we can go on, I thought Jim said that there were like 2,500 procedures and 1,000 of them were done where?

DR. MATHEWS: There are 2,500 procedures on the ASC list of which 1,000 were never done in that setting.

MR. JOHNSON: Where were they done?

DR. MATHEWS: Everywhere else.

MR. JOHNSON: Supposedly in the hospital outpatient or physician's office?

DR. MATHEWS: Or nowhere. But by definition, historically to get on the ASC list it had to be an inpatient procedure that could safely be done in the outpatient setting. So ostensibly at one point all of these things were predominantly inpatient procedures that have through technological advancement or some other factors have now become more and more common in ambulatory settings.

DR. CURRERI: For example, breast biopsy is a perfect example. 20 years ago they were all done in the hospital, now very few of them are done in a hospital.

DR. LEWERS: Spence, there could be things on that list that are still done inpatient, it's just they've never been moved there even though they feel it's safe to do it.

MR. JOHNSON: Right. Even at that, I guess one of my concerns is then on an ASC rate establishing basis, instead of the outpatient basis or the hospital cost basis, how do you make up a rate for this? When is it appropriate to move there?

DR. MATHEWS: HCFA has recently completed their survey of ASCs that is mandated to occur every five years which does collect cost data from these facilities, and that forms the basis for the rates that they proposed in their June or July NPRM.

MR. JOHNSON: But then we assume if we have that rate and we decided it was medically appropriate to do a patient in the hospital rather than the ASC that then there would be some factor on that ASC rate that would be increased to provide that service in the hospital if it was medically appropriate?

DR. NEWHOUSE: It would depend on cost.

MR. JOHNSON: I'm not sure Joe is saying yes.

DR. WILENSKY: He's saying it depends on the marginal cost of providing them in each of those settings.

MR. JOHNSON: I'm just concerned how that cost structure gets set.

DR. NEWHOUSE: In fact, you believe that with a separate building called the ASC that that might be more expensive than doing it in the hospital where you already have a facility there.

MR. JOHNSON: I'll let him go on, we won't solve this here.

MR. MacBAIN: And it seems like it is. From Jim's data it seems like it's more expensive in the ASC, plus the presence of ASCs drives up the cost of the hospital OPD.

DR. NEWHOUSE: There's a difference between accounting costs and economist's costs.

DR. LEWERS: Jim, before you go on with this list, and I assume you're going to leave this list, I don't know whether you know this --

DR. MATHEWS: I'd like to.

[Laughter.]

DR. LEWERS: Assuming you're going on, there's two items on here, injection of spinal canal, injection of spinal anesthetic. Did this include birthing centers? Are they classified as ASCs? Because I can't figure out any reason why you would be doing a spinal anesthetic.

DR. MATHEWS: These are Medicare claims.

DR. LEWERS: Where are we getting -- we've got disabled people or something. I mean, we've got 3 percent -- I don't understand why they hit the top 20. And I don't understand why follow up surgery of the eye does when a lot of those are global procedures.

DR. MATHEWS: I'm taking this straight from the claims.

DR. LEWERS: I figured that was the case. I'm really puzzled as to what would be done for --

DR. CURRERI: I think the injection of a spinal anesthetic is the predominant anesthetic used for lower abdominal and --

DR. LEWERS: None of these procedures would require a spinal anesthetic.

DR. WILENSKY: But you could use that as a separate -- that would just be off the claim. It doesn't mean that that is associated with the procedures above it, although if the anesthetic is there, presumably --

DR. LEWERS: Those three don't make sense to me standing alone. But we'll look at it later somehow. I don't know how.

DR. CURRERI: A lot of the injection in the spinal canal is for pain control, chronic pain, back pain, and so forth. The injection of spinal anesthesia is for a whole variety of operations that just don't happen to appear in the top 20.

DR. LEWERS: It's the other 80 percent. But still you would think that's awfully high.

DR. WILENSKY: It does seem high.

DR. LAVE: Is the anesthetic not part of a global fee?

DR. WILENSKY: No.

DR. LAVE: Not for the ambulatory care center?

DR. WILENSKY: Anesthesiologists cut a separate deal, period.

DR. MATHEWS: The point of this slide was that there's a lot of stuff on this list that just isn't done in the ASC setting and that calls into question the validity of the rates that are attached to those services. If the ASCs aren't doing them for that rate, there is very little to assume that anyone else is going to do it for that rate. That was the point I'm trying to make here.

DR. WILENSKY: Does that assume that that rate is always the lowest rate?

DR. MATHEWS: Not once the FDO reduction takes place.

DR. WILENSKY: I'm a little uneasy about making that assumption until we know more about what is going on. There seems like there's an awful lot of state specific regulation that could be affecting where these ASCs are and what they're doing. So I'd be a little uneasy to make that sort of blanket statement about if they're not being done in the ASC, the ASC rate will never be adequate.

It may be that that's correct but I'd want to see a comparison between the rates for doing that in the various places before you make that statement.

DR. MATHEWS: That's an excellent point. You should have sat in on the rehearsal for this.

DR. NEWHOUSE: Also what's correct on average -- there may be variation around the average. There may be some offices or outpatient departments that would find they could do it for the average ASC rate, even if the ASCs aren't doing it.

MR. GUTERMAN: Also as strange as it may be to believe, it may be that physicians are deciding to do surgery where it's appropriate to do it and they may decide not to do it in ASCs for other reasons than the payment rate.

MR. GREENBERG: There's a lot a huge range of what an ASC here. Some ASCs are physician offices by another name and they're formed only to get the facility fee. Other ASCs are multi-million dollar facilities, free-standing facilities, that are capitalized with physician or other income and have elaborate equipment or whatever.

So again, the notion that there's some uniformity in what we're talking about is difficult and a physician organizes -- if it's a physician's office by another name well, you'll do it at that price because you're getting an additional payment on top of your facility fee, which all of Jim's data of how much more the ASC facility fee is than the physician's practice expense --

DR. WILENSKY: And some of these things are joint ventures with hospitals, between the doctors and the hospital. And they set up an ASC as a joint venture.

There are a lot of reasons they were put together. Sometimes it's to escape the state regulatory structure. Sometimes it's to capture a facility fee that otherwise goes to the hospital if it's done by the docs. Sometimes it's the docs and the hospital trying to find a way to have revenues coming in that would otherwise go elsewhere.

MR GREENBERG: And a brief comment on the 1,000 procedures. The way the ASC has been generated in the past is a set of criteria that are based on a percentage of time procedures are performed in different settings.

So if you're 50 percent physician's office setting or more, you're by definition not on the ASC list. You had to be a minimum of 30 percent inpatient. Then you could vary among the other, but that produced a list of procedures that were eligible for payment.

It didn't mean that if anybody wanted to do it, anybody had the expertise to do them. And I don't think it says that much necessarily about the payment rate. It may say more about the list was generated. And the list has been changing, probably because under the old criteria the largest procedures, cataracts, fell off the list because they were no longer done 30 percent of the time inpatient.

So the Department had to come up with a new set of rules that allowed cataracts, which was the major procedure done in ASCs and more than 50 percent of the reimbursement, to continue to be done in an ASC. So they began to stretch the margins, which is one of the reasons that they have now

come up with a new set of criteria that isn't based on these numbers but it's based on presumably clinical criteria.

But that raises the issue that Jim is, I think, trying to bring forth in the slides, that there may be some other downsides of these two criteria. They may have opened up some other issues.

DR. MATHEWS: All of that sounded very familiar, for some reason.

[Laughter.]

DR. MATHEWS: The last thing that we investigated, in addition to where ASCs are and what they're doing, is the relationship of their presence on hospital outpatient services in those areas where both types of facilities serve Medicare patients. A partial list of some of the largest of these areas appears on this slide here, which showed that while the overall share of approved surgical procedures provided by ASCs is nationwide in the mid-teens, if I recall, in certain markets their share of these services is much higher.

For example, at the top of the list you see that in Sarasota-Bradenton, ASCs are providing 80 percent of the ambulatory surgery in that MSA.

DR. WILENSKY: We're going to send Anne in there to check it out.

DR. MATHEWS: We had two questions we wanted to investigate. The first is did ASCs have any effect on hospitals' charges for these services in these areas? That is, as I mentioned earlier, if ASCs were competing with hospitals to provide services to Medicare beneficiaries we might see some effect or some response among hospitals.

We found this wasn't the case, that of 14 of the highest volume ASC procedures provided in hospital outpatient departments in both 1991 and 1996, hospital charge growth was higher in MSAs where ASCs were present than in those with no ASCs in 12 of those 14 cases. For several procedures, hospital charges grew twice as fast in MSAs with ASCs than did hospital charges for the same procedure in areas without those facilities.

At the moment, we don't have a strong explanation for this phenomenon although we suspect it has something to do with the patterns of utilization rates in these two settings, which was our second topic of investigation.

DR. WILENSKY: I think it has more with more activities by the physicians in the area.

DR. MATHEWS: I wasn't going to say that, but...

DR. WILENSKY: I mean, these are, I think, indications of some increased entrepreneurial activities.

DR. MATHEWS: We also looked at utilization, specifically --

DR. LAVE: Can I ask a question? Can you compare the charges of the ASC with the charges of the OPD?

DR. MATHEWS: We aren't comparing the ASC charges to --

DR. LAVE: No, but you had an estimate here in terms of charges that was something to do with sort of competition. On the other hand, they may -- for Medicare the charges don't matter because they end up getting the same fee no matter what they have. So what they do with charges probably doesn't have much to do with the Medicare program. But it can have a lot to do with the private sector.

DR. MATHEWS: Right, but --

DR. LAVE: For instance, all of these are not cataract procedures, you'll notice, which is primarily a Medicare. Now the breast lesion, I don't know, it just seemed to me if you want to take a competition argument, you probably want a little bit comparative charges across the two, if they're competing based on charges.

On the Medicare program they can't be competing based on charges.

DR. MATHEWS: I don't think I mentioned ASC charges.

DR. LAVE: I know you didn't. But I'm sort of wondering whether or not it doesn't -- if you want to look at charges --

DR. NEWHOUSE: Transaction price.

DR. LAVE: I was also thinking that there are people in there who pay these transaction prices and that if you want to have a charge story, you probably want to look at comparative charges between the MSAs, meaning the hospital OPDs and the ASCs, rather than this change in charge.

DR. MATHEWS: So we could add columns or we could add a column for the ASC charges in those MSAs that have --

DR. NEWHOUSE: You don't have the transaction cost data on the private side.

DR. KEMPER: Where do you find them?

DR. MATHEWS: We also looked at volume. It's unclear on this slide, but it will be clearer on the next one. We looked at hospital outpatient volume stratified again by whether its MSA did or did not have an ASC. We found that hospital outpatient volume grew faster for services in areas with MSAs than without.

If I can have the next slide, you can see that the bottom two lines represent hospital outpatient growth in provision of services stratified by areas with and without ASCs. That top line is the corresponding ASC volume increase for the services listed along the bottom. As you can see, it's generally higher for ASCs.

DR. NEWHOUSE: Are you implying that supply is inducing demand or this demand growth is greater in the MSAs with ASCs?

DR. MATHEWS: We talked about a couple of possibilities and we we've decided that one thing that might be happening here is that the MSAs that we looked at, that have the highest numbers of ASCs are those southern Florida ones in a lot of cases which have had very fast, very rapid increases in the beneficiary population. So we think that maybe ASCs are picking up some demand that hospitals are not able to keep up with. It's a soft hypothesis but it might be more palatable than some of the alternatives.

DR. NEWHOUSE: Or they're entering in markets with beneficiary growth.

DR. WILENSKY: It's much easier to an ASC.

DR. MATHEWS: Right.

DR. WILENSKY: That's why this issue about state regulation, in areas where you're having rapid growth, getting an ASC started versus getting a hospital started -- especially if you don't really want to get into -- these are usually, I would gather, the more profitable procedures done separately. And that being able to set up an ASC cuts out a lot of things that are clearly not profitable, some of the burns, some of the trauma. And also, it escapes having to go through the whole structure development.

DR. CURRERI: I think another explanation might be practice patterns of the physicians. Where you have ambulatory surgical centers you generally get physicians who become very comfortable doing it in the hospital outpatient department or in the ambulatory surgery whereas in places where you tend to have only a hospital outpatient -- and these may be rural or smaller hospitals -- there's also some division where it's still being done as an inpatient.

I mean, I can name you several rural hospitals in Alabama where they just aren't comfortable because they aren't surgeons. They may be family practitioners who are doing hernia repairs, but still as inpatients.

So I think practice patterns may make a big difference to the volume changes.

DR. MATHEWS: In conclusion, I just wanted to reiterate the three main points of the analysis. One,

that ASCs are not uniformly available in all areas. Two, they don't provide the full range of ambulatory services. And three, that we don't completely understand the relationship between OPDs and ASCs in the markets that they do share.

These are some of the things that you might keep in mind generally as we talk about consistency of payment across these settings and rationalizing the payment systems that apply to them.

DR. CURRERI: Jim, I think that you have to broaden that. I really agree with what George said. I think it's not just HOPDs and ASCs that have to be compared, but office practice somehow. Because I can tell you, although Mobile, Alabama has no ASCs according to this, virtually 99 percent of all the cataract surgery is done in offices, but they really are set up as ambulatory. They may be charging as an office visit but, for all intents and purposes they have separate operating rooms and specialized nurses and all kinds of other things.

So I think that the trade-off is really between all three. You can't just look at two because I would guess that probably 1 percent of cataract extractions and lens implantation is done in a hospital outpatient department.

DR. LAVE: What proportion did you say?

DR. CURRERI: Probably less than or around 1 or 2 percent. I mean virtually all of them are done in what are essentially ASCs but they may not be classified as that because they may not have applied for an ASC license.

DR. MATHEWS: They're not showing up in large scale in the Medicare physician claims data though, which is where we might expect to see them as they weren't billing as ASCs. I think overall, in 1996 when we last looked at this, we determined that something like 3 percent of cataract surgeries were done nationwide in the physician office setting.

DR. CURRERI: Then you must be missing some ASCs. I can tell you of the five big ophthalmological practices, virtually all Medicare patients are done in the morning and they're done by the afternoon and home. I don't know whether it's because you're not picking up ASCs or what it is, but I know less than 10 percent are done in a hospital patient department.

DR. KEMPER: Jim, I thought this was a really nice analysis and underscored the complexity in translating our recommendation into actual practical payment policies. When you gave your outline of the March report it didn't seem to include the descriptive materials that you've gone through now. I would urge you to try to find some way to include them in the report because I think it gives a much better understanding of the difficulty of actually following through on this.

DR. MATHEWS: I would also just like to ask the Commission to keep in mind that this is very much a work in progress but I wanted to put it on the table because I have been promising some data for a long time now and give you a feel of how we've been approaching some of these issues, and give you some context to a lot of the theoretical discussion that we've had so far. So if you do have any other guidance on this, I could definitely use it.

DR. WILENSKY: Any further comments or questions?

For the commissioners, tomorrow we're going to start the executive session at 8:45 rather than 8:30. Joe and I have a 7:30 meeting and in response to Bill MacBain's reasonable request I think we probably will be not back here at 8:30 sharp, but we should be able to be back here by 8:45 so we'll plan on starting at 8:45.

MR. FISE: I'm sorry, I missed the bell on the public comment, is it still available?

DR. WILENSKY: Sure.

MR. FISE: My name is Tom Fise and I'm the executive director of the American College of Gastroenterology and have been very interested in the commentary with respect to differential payment that we've observed.

The statement that we're passing around obviously was prepared before that dialogue but I'd like to just underscore a couple of things very briefly and ask perhaps that the statement be entered into your records.

We have been concerned, and this deals with not the ambulatory surgical center rule but with the practice expense and the Medicare fee schedule generally, with the change in the site of service differential policy that has been implemented. We believe that paying a different professional fee to a physician based on where procedures are performed is a bad idea whether the physician fee is higher in the ASC or hospital or if it's higher in the office.

We think that financial incentives intervene which can interfere with what should be the sole criterion for a choice of venue, namely what is best for the patient. So with the change in the site of service rule, HCFA finds itself in the anomalous position of having established a set of safety related guidelines for ambulatory surgery centers which have to be met in order to gain Medicare certification, but not proposing to pay more for physicians if they perform procedures outside Medicare certified facilities. Protections as to training, ability to deal with complications, and other patient assurances may be reduced in the office setting.

Contrasting from the 50 percent standard that was established under the old site of service rule, fewer than 5 percent of endoscopic procedures are now performed in an office setting. The true number may be much lower than that because Medicare records procedures as in the office in many instances where the facility may otherwise meet the Medicare criteria but for certificate of need purposes or whatever is not officially a Medicare certified facility.

With the change in the standard it remains unclear what criteria or standard HCFA now has or will be using to differentiate those services subject to the new bifurcated fee from those that remain subject to a single fee. So we think that HCFA's new policy merits some reexamination and we would urge the commission to address these issues as you look at the differential payment concerns.

So we thank you very much and would be happy to be involved in any dialogue at a later point.

DR. WILENSKY: Thank you very much. Any further comment?

Thank you for your patience.

[Whereupon, at 5:32 p.m., the meeting was recessed, to reconvene at 9:00 a.m., on Tuesday,
December 15, 1998.]

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Embassy Suites
1250 22nd Street, N.W.
Washington, D.C.
Tuesday, December 15, 1998

The meeting in the above-entitled matter

convened, pursuant to notice at 9:31 a.m.

COMMISSIONERS PRESENT:

C O N T E N T S

P R O C E E D I N G S [9:31 a.m.]

DR. WILENSKY: Let's get started.

DR. WEINRAUCH: Good morning. Today we will continue our discussion on physician workforce issues. Last time we talked about specialty mix and physician supply. Today we will talk about international medical graduates and geographic distribution.

The basic issues we wish the commission to consider are what role do IMGs play in the physician workforce? That is what is the role in specialty balance or imbalance and in serving underserved communities? And secondly, what role should the government and health care industry play in providing training opportunities for international medical graduates?

International medical graduates are defined as a foreign national or a U.S. citizen graduating from a foreign medical school. A U.S. medical graduate is either a U.S. citizen or a foreign national graduating from a U.S. or Canadian medical school. So it is where one graduates from medical school that determines whether or not one is an IMG.

There are basically four types of international medical graduates: a U.S. citizen which includes both native and naturalized permanent resident, foreign born IMGs with exchange J-1 visitor visas, and foreign born IMGs here with temporary H-1B visas.

The exchange J-1 visitor visa provides the opportunity for foreign nationals to gain knowledge and professional training in the United States and then to transfer these skills back to their home country. They are subject to a two year home requirement. That is they must return to their home country for at least two year after completing training.

The temporary H-1B visa is also a non-immigrant visa but it lacks the two year home requirement. It has been used increasingly more frequently to circumvent the two year home requirement. Between 1988 and '97, the greatest increase in terms of growth in the percent of total IMG residents is evident in the temporary and exchange visa classifications.

DR. LAVE: Can I ask a question? Is this for the resident population or for the practicing physician? And can we know it for the residents?

DR. WEINRAUCH: It's the residents.

MR. SHEA: These visas are limited, right, in all cases?

DR. WEINRAUCH: Limited in terms of?

MR. SHEA: Are they time limited in some way?

DR. WEINRAUCH: Yes, how many years they can stay here on those visas, right? Six to seven years.

MR. SHEA: In addition to this two year --

DR. WEINRAUCH: Right. There have been a number of proposals related to immigration policy. These are discussed in the paper and will be addressed at a later date.

This graph shows the growth in our supply of practicing physicians excluding residents. We can see that IMGs are remaining in or returning to the United States and adding to our supply of physicians. And over time they are composing a greater percent of our workforce.

In 1970, 13.9 percent of the physician workforce was composed of IMGs. In 1995 the percent was 23.5. There is no recent data but one study in 1984 estimated that 70
to 75 percent that IMGs in training positions either remain in or return to the United States to practice medicine.

From 1990 to 1997 the percent of residents that are IMGs increased from 18 to 25 percent with most of the action shown between 1990 and '93. Although not shown on this graph, between 1993 and '97, the number of U.S. medical graduates slightly decreased. The number of PG-Y1 IMGs decreased, while the total number of IMGs increased. The implications are that IMGs remain longer in

training and enter specialty programs. USMGs leave earlier, after first board certification, and IMGs enter later at more advanced levels. We will be returning to this issue.

IMGs are concentrated geographically. In New York almost one-half of the residents are IMGs and over half of IMGs are located in these five states.

DR. ROWE: Is this of all the IMGs half are in New York? Or half of all the residents in New York are IMGs? The latter?

DR. NEWHOUSE: These five states are half the IMGs, together.

DR. WEINRAUCH: Now we will address the role of IMGs in specialty balance or imbalance. True, a slightly a greater proportion of U.S. medical graduates are in specialty care than international medical graduates and a slightly greater percent of IMGs are in primary care than are U.S. medical graduates.

Between 1990 and '97 there was a greater growth in the number of residents training in primary care than in specialty care, but all the growth in specialty training is being driven by IMGs between these years.

Now we will look at the issue of IMGs fulfilling an unmet need by providing care to underserved communities. Many studies suggest that international medical graduates aggravate the problem of uneven physician distribution and that IMGs tend to settle in urban areas which might challenge the hypothesis that IMGs are gap-filling in serving an unmet need.

Here we see IMGs concentrating in the highest metropolitan areas and they are concentrating there moreso than are U.S. medical graduates.

DR. ROWE: Can we see that again? The rural/urban code continuum, what does that mean?

DR. WEINRAUCH: Zero is the most dense and nine is the most rural, less populated.

DR. ROWE: So the higher the number the more rural?

DR. WEINRAUCH: Right.

DR. CURRERI: So this shows actually that the IMGs are concentrated in the urban areas?

DR. WEINRAUCH: Right, moreso than the U.S.

MR. JOHNSON: Could they not be meeting an unmet need in an urban area as well as a rural area?

DR. WEINRAUCH: We're going to get to that.

DR. LAVE: It would be useful in these tables to present them both one way, once as a percent of physician distribution, so that you had 100 percent adding in the column as opposed to across the rows. You could see it more dramatically that way.

DR. WEINRAUCH: This study focused on the post-resident workforce in primary care and examined the possible distributional differences between IMGs and USMGs with the needy counties. The four indicators of need which were examined were high infant mortality rate, high poverty level, non-white race, and rural areas. All are often indicators of poor health status and/or poor access to health care.

The number of U.S. medical graduates are normally greater than the numbers of international medical graduates regardless of geographic boundary, but here we are looking at the propensity of IMGs or USMGs to practice in needy areas. One might argue that finding IMGs disproportionately in needy counties would support their safety net role. In this study, three out of the four indicators leaned towards IMGs. 19.4 percent of U.S. medical graduate primary care physicians practice in counties with high infant mortality, compared with 22.5 percent of IMGs.

Although U.S. medical graduates may have a greater likelihood of practicing in rural areas, several studies suggest that within these rural areas IMGs are fulfilling an unmet need.

These are the states with the lowest physician to population ratios in rural areas. Four out of five states had the vast majority of growth in physicians due to IMGs. Further, this is consistent with other evidence that IMGs make up a greater percent of the physician workforce in rural underserved areas than in rural non-underserved areas as defined by HPSAs.

For a majority of cities, IMGs frequently are found across poverty and non-poverty areas, more or less like U.S. medical graduates. For the larger cities, however, there is a slightly higher propensity of IMGs to be in poverty areas. But in these areas, the propensity is relatively small even though the author found the differences to be statistically significant.

The next few overheads are based on preliminary analysis which we will be updating. The main point here is that public municipal hospitals have the highest percent of IMGs.

DR. ROWE: This is as residents, not as -- the other data were in office practice or in practice? This is during the training period.

DR. WEINRAUCH: Right, these are residents now. The next few slides are residents.

This table shows that 30 percent of hospitals have no IMGs. For two-thirds of hospitals, less than 20 percent of residents are IMGs. Less than one-fifth or 19 hospitals are composed of at least 40 percent IMGs and are training 19 percent of all residents but about one-half of all IMGs. Basically, there are a lot of hospitals with either no IMGs or proportionately few IMGs.

One of the concerns when addressing cutbacks in international medical graduates is that many hospitals rely on IMG residents to provide care to the poor. So we looked at teaching hospitals and their DSH percentage as a proxy for the measure of caring for the medically indigent. So this here would try to show if hospitals with a higher percent of IMGs, and presumably more IMG dependent, serve a disproportionate share of underserved people as evidenced by DSH percent.

We chose 40 percent to establish IMG dependency because it was about twice the national average of percent of total residents that were IMGs in '94. Surprisingly, at the high DSH end, there is not a higher proportion of hospitals that were IMG dependent than hospitals in the low or middle DSH categories. But yes, there is a slightly higher proportion of IMG dependent hospitals in the two higher groups than in the low DSH end.

Again, we will leave you with these questions.

DR. ROWE: Can you go back and explain, just for a second for me, I'm sorry, perhaps some of my colleagues have questions. Explain these two visas, this J-1 and the H-1B visa, what they mean and what they don't mean, and how long they can be here and whether you have to go back?

DR. WEINRAUCH: The J-1 visa is the one with the home requirement and the H-1B visa does not have the home requirement. But to get the H-1B visa you have to take step three first, before coming here. In most states, you have to have GME before taking step three. So only in a certain number of states would you be eligible for the H-1B visa.

Both of them you can be here for six to seven years and then people with H-1B visas will try and get a permanent resident status, which would keep them in here. It would facilitate their entry to the U.S. And then for the J-1 visa, there's lots of waivers that can be granted so that the two year home requirement, they won't have to go back.

MR. SHEA: But the basic issue here is the J-1 is an education and training situation, right? An H-1B is a lack of a U.S. workforce. You get an H-1B visa, you have to attest as an employer that you can't find such a person.

DR. WEINRAUCH: Right, and it's employer-specific, right.

DR. ROWE: The J-1 is really you're here to train and go back, but there are a lot of waivers?

DR. WEINRAUCH: Right, that's the original intent, was that they would train and go back.

DR. ROWE: What would be interesting, I think, would be if you could generate some data in terms of the actual function as opposed to the intent or the original intent of these visas, so that for whatever year, take a year three years ago or whatever, how many people with J-1 visas are still here and got waivers? Is it 90 percent? Is it 2 percent? So we have some sense of how it's actually functioning.

DR. WEINRAUCH: We have the number of waivers that have been granted over the last five years.

DR. LONG: Can we also find out how many people, in fact, go back for two years and then return to the U.S.?

DR. WEINRAUCH: For now, we haven't been able to find any good data on that.

DR. MYERS: The INS should have that.

DR. LEWERS: The data is available on the percent, though, that do not go back. That's a very high percentage. I think it's 70 percent, but I'm not positive of that figure. I don't know if the numbers are available for those that go and then come back.

DR. WEINRAUCH: The 70 to 75 percent is who eventually either returns or remains. That includes people that go home and come back.

DR. NEWHOUSE: I think that also includes the U.S. citizens.

DR. ROWE: We might include that in the chapter, I guess, some description of the function, some data.

MR. LISK: The waiver requests have increased dramatically for the J-1 visa. Some of that is changes in the laws that allowed for states to have waiver requests, for instances. There were supposedly 70 in 1990 and in 1995 there were 1,374.

DR. ROWE: Still, it seems like a high number but a relatively low number compared to the total number that are offered, total number of visas.

MR. SHEA: Is that just in health care?

MR. LISK: That's supposedly physicians.

MR. SHEA: The next step here is drafting a chapter? Or we're looking at something before a draft because we don't have a chapter?

DR. WILENSKY: Right. There was information in the November report. There was text in a November report. We didn't get to the discussion because the other discussion was going well. We chose not to cut it off.

These were the tables that went with it. We can go back to the last month or we can send it to you, but in general we are not asking you to vote or make recommendations. This was the set of overheads that went with the text last time in its next iteration.

MR. SHEA: So we actually got a draft chapter last time?

DR. ROSS: I wouldn't even call it a draft chapter. It was a paper.

DR. WILENSKY: The materials that we've been sending, unlike what our habit for the March and June report, where typically you get material that is background for a chapter or a chapter with some recommendations as we have shared with you this time. And then in the next meeting presumably you'll get your final cut on recommendations.

Because of the nature of this material we have taken longer times to develop it by putting out background information, having discussion follow that will lead to what will be more closely defined as draft chapters. So you will have written material but they probably ought not to be regarded really as very much of a draft chapter.

MR. SHEA: So we're moving just towards the report writing, not towards chapters in the March --

DR. WILENSKY: This is report writing for August.

DR. LAVE: Do we have, or do you have, an explanation for why the increase in the IMGs took such a big upturn in -- it looks as if it's in about 1990? Is that when you first figured out how much each resident was worth? The average resident is worth $100,000.

DR. WILENSKY: Can you pull the microphone closer?

DR. LAVE: There was a big increase in the late 1980s and the question is there an explanation for that, other than the fact that the teaching programs finally figured out how much each resident was worth?

MR. LISK: There was a huge increase in the numbers of visas issued, in terms of the type of visas and also the growth in actually even permanent residents over the period. Actually, U.S. citizens there wasn't much of a change, both naturalized and natural born. But it's not clear to me why there was such a big increase.

The patterns, though, of the type of IMGs did change, though. I don't know whether it may have been a process of knowing where to get people from, in terms of other medical schools in other countries and stuff. I'm not clear to why there was such the large increase that occurred. But it does -- a lot of that big increase really was from IMGs though, compared to U.S. medical graduates.

MR. SHEA: Or why it leveled off in the '93 to '97?

DR. WEINRAUCH: PG-Y1s were decreasing in IMGs.

MR. LISK: That's most recently, not in this period. There was a substantial increase in the number of first year residents, also, in this period too.

DR. LEWERS: Just to go back to Hugh's question, on page five of the paper that we received in November, it states that one study in '94 estimated that 70 to 75 percent of all IMGs enrolled in GME either remained in the U.S. or returned to the U.S. to practice medicine after completed training. And that's the definition that they have used of IMGs. That's the U.S. who were trained overseas. So that's both.

I think there are several obvious -- we could discuss this one issue for a long time. It's very complicated. It's not an easy one.

I think we have to go back and look at history, because basically -- and I believe it was about 20 years ago, I think, when we really began changing the visa status. I'm not positive of my dates on that. But we did that because we asked this community to come in and help us full a void at that time. And they did so.

In AMA we have been in contact with some of the foreign countries where they're very concerned about our policies because of what they're classifying as a brain drain. Their brightest and best are coming here and end up staying here. They're very concerned and they're also watching what we're doing in this framework.

But we've also gotten into a status now which I think is inappropriate, where there is a lot of discrimination going on against this group. For instance, I was with a series of IMGs about a week ago. And one of them, who is a U.S. citizen and whose children have grown up in this country, and because of their name, this is a student that went to one of the very well known colleges, graduated with honors, and because of the name was told don't apply, we don't take IMGs. And this is not an IMG. This is an American citizen, born here, trained here, and can't get a job just because of the name. I think that's deplorable.

But we do have to do something about this. We've got 180,000 people in the pipeline right now to enter into this program in this country. 180,000. The residency slots, we've got enough to fill 140 percent of those. And that's why a lot of people have looked at dropping it down to the 110. And that may be an answer.

But I personally feel that the answer is to look at the waivers. I think we've got to cut down on the various visa waivers that are occurring, and if these individuals come here for training they

have to go home. I think one of the questions that we're being asked here is what role should the government play in the training opportunities is probably the key one in funding those areas. And I think that's going to be the very difficult one for us to answer.

So I think we've got a lot of work to do in this area. I think the paper was very helpful that we received, and if you all haven't seen it recently, I'd suggest you review it. It's got an awful lot of very good information.

DR. WILENSKY: Should we stop to discuss this or should we go through the second piece. Craig, would you find it more useful?

MR. LISK: It's really up to you and how you want your discussion to flow.

DR. LAVE: Can I ask a question about the 110 percent issue? Maybe you can sort of indicate briefly, but I've seen a whole host of proposals who have said they ought to limit the paid Medicare slots to 110 percent. Have those been followed up with how one would do that? Only because to say that you would do it, given that the proportion of IMGs to USMGs varies from hospital to hospital. I was just very curious about whether or not any of the people who have made that proposal have also made a proposal about how it would be implemented?

DR. WILENSKY: Operationally? Why don't we hold that for a minute. I don't know the answer to that and maybe somebody here does.

Why don't we go through the second piece of it because, in many ways, it's really the same issue because it's the distribution issue. And then we'll open up the discussion for both pieces.

MS. GOLDBERG: Today I will present data that describe the current geographic distribution of patient care, physicians, and residents. As you'll see, the physician workforce of the United States is not evenly dispersed. Rural and inner-city areas are especially prone to problems.

I will also explain current federal policies that affect the geographic distribution of physicians and residents. Finally, I will conclude by suggesting issues for the commission to consider.

This slide presents data for those states
that have the highest number of patient care physicians
per 100,000 population. Northeastern urban states tend to have the highest patient care physician to population ratios. Massachusetts led the nation in 1996 and New York was second.

DR. ROWE: You've taken residents out of this?

MS. GOLDBERG: This is just patient care physicians and I'll present resident data after I present data on physicians.

DR. ROWE: I just wanted to make sure it's clear what we're looking at. This does not include people who are in residency?

MS. GOLDBERG: My first three slides are all on patient care physicians. The second three slides are on residents.

DR. WILENSKY: Residents are included in that.

MR. LISK: Yes, but this is excluding residents.

DR. ROWE: They're included generally under patient care physicians but I think these data [inaudible.]

MR. MacBAIN: For purposes of comparison, what is the national average across all 50 states?

MS. GOLDBERG: 202 per 100,000 population.

DR. CURRERI: Just to clarify, does this include residents or does it not?

MS. GOLDBERG: It does not. I'm sorry if that wasn't clear. This does not include residents.

The second slide illustrates that states with the lowest patient care physician to population ratios are predominantly rural states. In 1996 Mississippi and Idaho had physician to population ratios of

only 138. This is the lowest in the nation. Arkansas, Wyoming and Oklahoma also had relatively low ratios.

This map was taken from the 1998 Dartmouth Atlas of Health Care. It allows you to visualize how the patient care physician to population ratio -- and this is again not including residents -- varies throughout the United States by hospital referral region. The Dartmouth atlas divided the nation into 306 hospital referral regions according to where Medicare patients were hospitalized for major cardiovascular surgical procedures and neurosurgery.

Each hospital referral region contained at least one city. Dark shading indicates where physician supply is highest and light shading indicates where physician supply is lowest. So looking at the map up there, you can see that California, much of the northwest, parts of the southwest, mountain states and part of the Pacific northwest have especially high physician to population ratios. Nebraska, New Mexico and Idaho, parts of the middle of the country, have particularly low ratios.

DR. ROWE: Nebraska also has the longest life expectancy in the United States.

[Laughter.]

DR. ROWE: Whether they're related or not, I can't say.

DR. LONG: Is that because the physicians live longer?

MS. GOLDBERG: The next three slides that I will present to you pertain specifically to residents. This slide shows data for those states with the highest resident to population ratio. Northeastern states with large urban populations tend to have not only the highest physician to population ratios but also the highest resident to population ratios.

Academic health centers are located in urban areas and therefore residents are also concentrated in urban areas. Only 5 percent of teaching hospitals are in rural areas.

New York has the highest resident to population ratio. In 1997 there were 82 residents per 100,000 New Yorkers. Massachusetts is second, but the ratio is substantially lower than New York's. To put that in reference, the national average is 39 residents per 100,000 population.

This slide illustrates that the majority or 55.5 percent of all of our nations residents train in only eight states. And New York trains more residents than any other state.

DR. LAVE: Why isn't Maryland on this thing?

DR. ROWE: Johns Hopkins is a separate state. They're about to annex into New York City.

[Laughter.]

MS. GOLDBERG: Maryland was sixth or seventh, I think or lower. It was slightly lower.

Moving on to the next slide, although only a handful of states train the majority of residents, there are many states that train relatively few residents. 22 states and Puerto Rico train a total of 12.2 percent of all residents. There are four states that provide no in-state training of residents, although Washington state trains residents from these four rural states, which include Wyoming, Montana, Idaho, and Alaska.

The distribution of practicing physicians and the distribution of residents does not match with the distribution of the American population. Approximately 90 percent of all practicing physicians and almost all residents are located in urban areas. However, 20 percent of the American population resides in rural areas.

In 1996 there were 203 practicing physicians
per 100,000 population in urban areas. Rural areas had less than half the supply of urban areas.

Designation criteria are used by the federal government to assess need and allocate resources. As of September of this year there were about 3,680 designated medically underserved populations or areas and there were about 4,500 federally designated health professional shortage areas,

or HPSAs. Many areas are designated as both medically underserved and shortage areas. Approximately 62 percent or roughly 2,800 of all HPSAs were primary care health professional shortage areas. The remainder were dental or mental health HPSAs.

Fulfilling the need of currently designated primary care shortage areas would require placement of an additional 5,541 primary care physicians based on a ratio of one physician for 3,500 population. If we use a ratio of one physician per 2,000 population, which is currently the industry standard, we would require the placement of an additional 12,484 primary care clinicians to fulfill the needs of primary medical HPSAs.

60 percent of designated shortage areas are located in rural areas. Most other shortage areas are in inner cities. There are currently about 2,300 National Health Service Corps professionals in the field. Although National Health Service Corps clinicians address unmet health care needs in underserved communities while they are in the Corps and many clinicians do actually remain in underserved areas, retention upon completion of assignment is an issue.

A 1996 study found that one-quarter of National Health Service Corps providers placed on assignment during the early 1980s were still in their original assignment county six years after their obligation had ended. Another study done in 1997 showed that about 40 percent of National Health Service Corps physician providers placed on assignment between 1975 and 1983 were still practicing in a rural location in 1991, although that rural location was not necessarily a HPSA.

The Department of Health and Human Services proposed a rule that would affect how HPSAs and medically underserved populations and areas are designated. The comment period on the rule was supposed to end in November, but it was extended to January 4th of '99. Under the proposed rule, HPSAs would become a subset of medically underserved populations to consolidate overlap.

In addition, medically underserved populations and areas would be updated annually. Currently, they're not updated. However, HPSAs are updated annually.

Although the new designation criteria would count physicians assistants, nurse practitioners and certified nurse mid-wives as 0.5 full-time equivalents in determining primary care need, it's not clear how this would occur and how to count non-physician practitioners. In addition, data are likely to make counting difficult and there is a lot of state-to-state variation in terms of the types of tasks these clinicians are allowed to perform.

Finally, the proposed rule would add four new criteria for designation of medically underserved areas and populations. Currently, underserved need is determined by characteristics including county physician to population ratio, infant mortality rate or low birth weight rate, poverty rate, and the distance or time required to obtain comprehensive primary care.

New criteria would also include the percent of the population that is Black, Asian, Pacific Islander, Native American and other non-whites; the percent of the population that is of Hispanic ethnicity; the percent of the population in which no one over the age of 14 speaks English well; and population density measured as population per square mile.

There are two main types of federal policies that influence the geographic distribution of physician: workforce policies and health care payment policies. Health care workforce legislation in the Public Health Service Act authorizes federal funding of grant, loan, loan repayment, and scholarship programs; centers and clinics; and the National Health Service Corps.

Federal centers and clinics and federal grant, loan and scholarship programs are designated to address the needs of designated medically underserved populations or designated medically underserved areas. The National Health Service Corps is specifically designated to address the needs of designated HPSAs.

HPSA designation may be based on geographic area, population group, or facility needs. In general, rural areas tend to be designated because of geographic need and urban areas tend to be

designated because of population or facility needs. Facilities are not-for-profit outpatient facilities, including correctional facilities.

As Deborah Walter explained at the November meeting, the Public Health Service has extensive requirements for its outlays for graduate medical education, although they provide only 1 percent of all federal outlays for graduate medical education. These highly targeted funds are allocated according to federal designation of need.

Unlike workforce problems our nation's health care payment programs, including Medicare and Medicaid, were not designed to address problems related to the geographic distribution of the physician workforce. However, Medicare and Medicaid have become the main vehicles through which the federal government supports training of physicians.

Currently, Medicare does not offer geographic proscriptions as to where training funds should be spent. However, Medicare does offer incentives to practice in shortage areas and to provide care to medically underserved populations. Physicians that provide services in areas designated as geographic shortage areas receive what's called an medical incentive payment or an MIP that's 10 percent above the regular Medicare reimbursement rate.

In addition, World Health clinics and federally qualified health clinics, which were designated as such because of the areas or populations they serve, are eligible for reasonable cost-based Medicare and Medicaid reimbursement. However, a point to note is that the Balanced Budget Act requires a phase-in of a decrease in Medicaid cost-based reimbursement to federally qualified health clinics.

The federal government has attempted to address physician shortage needs not only through workforce and health care payment outlays, but also through the use of telehealth, telemedicine and informatics. These technologies have the potential to address some of the needs of underserved populations in areas, although there are costs and legal issues associated with their use.

Telehealth is the remote delivery of health care. Telemedicine is the remote practice of medicine. Medical informatics is defined in the BBA as the use of biomedical information in problem solving or decisionmaking by applying computing and communications technologies.

The BBA directs the Secretary of Health and Human Services to make payments from Medicare Part B for professional consultations via telecommunications systems. The Act only covers services provided to beneficiaries who live in HPSAs. However, the Department is supposed to evaluate the possibility of expanding payments to include those beneficiaries that do not reside in a HPSA but are homebound or nursing home bound and for whom being transferred imposes serious hardship. The Secretary's report is due to Congress on January 1st, 1999.

In addition, the Secretary is supposed to submit another report on January 1st which involves an analysis of how telemedicine and telehealth are expanding access to health care; the clinical efficacy, cost effectiveness, and quality of telemedicine and telehealth services; and the reasonable cost of telecommunications charges incurred in practicing telemedicine and telehealth in rural, frontier, and underserved areas.

Finally, the BBA establishes an informatics, telemedicine, and education demonstration project. The project will use high capacity computing and health care provider telemedicine networks to improve the quality of primary care delivered to diabetic Medicare beneficiaries who are residents of medically underserved areas.

In trying to develop recommendations related to the geographic distribution of physicians, there are several issues that the commission may wish to consider. First, what are the implications of a geographic maldistribution of physicians? Second, does the growth in overall physician supply benefit underserved communities? Third, how effective are current federal policies? And finally, to what extent are underserved communities reliant on international medical graduates and non-physician clinicians?

DR. WILENSKY: Let me open up for questions?

DR. ROWE: To what extent do these data include the Veterans Administration, the Department of Defense, the Indian Health Service? This is always a question when we look at these data. And whether you take those groups in or out, does it really have any impact on any of the conclusions that you reach?

MR. LISK: For the data that Janet presented, it was non-federal physicians. So that would not have included the VA and DOD. And the problem with the Indian Health Service is -- I'm not sure, in terms of that other chart that you saw, whether that was federal and non-federal or just non-federal physicians.

DR. ROWE: I think when we get to writing the chapter up, we should have a section that just describes those entities and how large they are, and so one can get a sense of whether they're really important to these overall implications of these data or not. I mean, just because it's always confusing as to whether they're in it.

The VA has 170-something medical centers and the DOD serves a very large Medicare beneficiary population theoretically of retired service people who live around military installations. So from a Medicare point of view, those two are important providers.

DR. NEWHOUSE: I think it's going to be easier for us to have this discussion if we can talk about how we think physicians locate. My view of this, based on several years of reading and somewhat contributing to the literature, is that physicians, like most other people, tend to follow the demand for their services when they consider where to locate. And they also consider amenities.

So for example, I would note in your high states and your low states, the high states tend to be high income states. In fact, I think without exception they're probably all in the top 10 per capita income. And the low states tend to be low income states. High income states have a higher demand for physician services than lower income states.

Now there are several things that follow from that, if you think that that's how physicians locate. One is, in terms of the IMG discussion, it's just wrong to assume that if the IMGs all dropped dead overnight that over time the market wouldn't re-allocate. There would be some demand for services that was not being currently filled by an IMG that would not be filled. And presumably some USMGs would move in.

It's also the case that, in terms of the notion that the IMGs are disproportionately in disadvantaged areas, which I think on the whole they are as your data show, that this makes sense if you go head-to-head between a USMG and an IMG if on balance there's a preference of patients for the USMG. Then the USMG is going to have areas with higher demand that are more desirable than the IMG.

I'm concerned about the use of a couple of the numbers. One is the rural physician to population ratio numbers that cropped up on one slide. The implicit assumption in using that number as a measure of access is that the rural population uses rural doctors. But for a lot of the rural population, the closest doctor is actually in a metropolitan area.

So if you take the share of the population in rural areas whose closest doctor is in a metropolitan area and you put them over in the metropolitan population, it doesn't really do much of course for the metropolitan physician to population ratio because you're putting a small number in the denominator of the big number. But it can do quite a bit for the rural number. And the numbers tend to equalize.

MR. LISK: Actually, it's not published yet and there was someone I had talked to out at University of Washington on a study that they were doing, actually in Washington state though in terms of the rural communities, and so it's a limited study. But they found actually for primary care physicians for residents living in rural areas there was about 97 or 98 percent were going to physicians in the rural

areas in that communities. For specialty care it was about 80 percent were going to physicians in those rural areas.

DR. WILENSKY: That is not true, at least in other areas.

MR. LISK: That was a study just done in Washington state.

DR. NEWHOUSE: I've looked at some other states and it's not true.

DR. WILENSKY: It's not true. I've done some analysis for some of the people using services in the Appalachian areas. And not surprisingly that for specialty care in particular they're much more likely to go to Pittsburgh and Charleston and not into the counties in which they live for their specialty care.

So it may be true in some areas but it's definitely not generalized.

DR. NEWHOUSE: The data I did look at, this was a number of years ago now when I was working on this, and it's possible that there's more primary care physicians out in rural areas now. But at least it was true then.

The last thing, a comment on Judy's question, how would you operationalize this policy? I remember a discussion we had on PPRC in the Clinton reform era where this was actually an issue because there was going to be an allocation of residency slots. Of course, this question came up as part of the Health Security Act debate.

There was a dean of a medical school that came here and was arguing for very decentralized allocation of residency slots. The opposing position was that it all be done out of Washington. The dean said well, his state -- which was a rural state -- if Washington took away their orthopedic residency program he didn't think there would be any orthopedic physicians that would come.

And Bob Keller, who was on PPRC at that point, who was an orthopedic surgeon in Maine, said to him gee, we don't have any orthopedic residency training programs in Maine but we managed to get orthopedic surgeons to come to Maine, suggesting the market would work.

But Judy's question is well taken. I mean, this is --

DR. LAVE: I could think of ways to do it but it's not easy.

DR. WILENSKY: We could go back and look in some of the past legislation about whether it has existed.

DR. CURRERI: I enjoyed this presentation very much. I was appreciative of the studies that you looked at in the HPSA areas as to what the retention was in the long run.

But I think we need to get more information in that area, not necessarily from the HPSA, because the HPSA physicians have a pretty long commitment, number one, usually. Number two, they are people very often that have loan needs to make up loans, so that's what attracts them there. So that may selectively look at physicians that are more prone to stay in that area where they started their practice or a rural area.

I say this because having taught both in rural medical schools as well as in metropolitan medical schools and having watched many, many students come through who came from rural areas and were quite dedicated when they entered medical school to go back there, what I found is that when they did go back and practice, primarily in primary care, that after two or three years they usually gravitated to a more metropolitan area.

The reasons for that were several. First, there was some burnout because if you're the only primary care doctor in a rural area, you never have a vacation. When you decide to go somewhere you feel guilty if somebody is sick. There's a real problem there.

But the biggest migration occurred when their children started to enter school and they perceived that education was perhaps not as good as it would be in a metropolitan center, and the advantages of computers and all kinds of other things, forced them to move not necessarily back to a big urban center but to a more metropolitan center.

So I think we need to look at those as I was struck how often, when those children hit first grade, how soon after that they begin to migrate.

In the urban centers there is another reason and the most common reason I saw people leave disenfranchised or poverty areas in the urban centers were matters of safety. I think we have to look at that. Residents that I trained in New York often practiced in poorer areas but the third time their office was robbed for narcotics or whatever they got out because they were afraid that there was a safety factor involved.

Those things, to me, seem much more important in the distribution of physicians than little salary bonuses and so forth. I don't think, in the long term, those are very meaningful to the vast majority of physicians. I think it's these ancillary things. And if we could get any data about this, I mean these are just my own anecdotal observations but I think this is something we really need to look at because we aren't going to fix the situation until we can figure out how to change those things.

MR. LISK: That's a very good point, I think, that those are some of the main issues in the geographic distribution. We had the Office of Rural Health come in and talk to us and one of the things they pointed out was that some of the rural areas, in terms of the HPSAs, they have to keep having National Health Service Corps people going in there for a couple of years, and not the same person, because either there's not enough population to sustain them and the problems of having only really one physician practicing for that community, but also educational and other amenity type of issues in some of those really remote areas, too. That does travel down, in terms of the desirability of the communities to practice.

DR. WILENSKY: Let me just make a plea, we're substantially behind schedule. If we can try to keep questions and comments a little shorter.

DR. LAVE: I had two comments and they're really kind of in-line, one of which is that since we've mentioned the HPSAs and the MUAs it might be useful to have the USMGs and the IMGs on that basis as well, since that's the one that we talked about, including what we've had.

Secondly, I like the way that the conversation is going on where the physicians are located because I think it's terribly important to sort of have a model in your head about why people are where they are to develop appropriate policies. I think it may be that the only way you're going to get there is have a person come a year at a time and try to pretend you can do something different.

The third thing is, though, that I think it would be useful on the urban/rural one -- and this is a somewhat different take -- is to sort of notice that, in fact, that for some physicians you need to have a very large population in order to make that practice viable. So there are just a whole hosts of specialists that you would never expect to see take place in the rural areas.

So these distributions are actually not very meaningful and I think they lead to inappropriate policy conclusions. You say isn't this awful, 20 percent of the population and only 11 percent of the practicing physicians. But you wouldn't expect to see a neurosurgeon and maybe a top-grade orthopedic surgeon or even an ophthalmologist. They just wouldn't have enough patients in some of those rural counties to, in fact, have a viable practice. So I think one has to consider that.

The other thing that I think is somewhat useful and we might not want to get into it, though, is to sort of indicate that my read on the data is that the health in rural areas is not that bad and so -- you know, there have been a lot of studies on this.

So I think it would actually be useful that if we make things better we are talking about marginal improvements in health. We're not talking about significant major changes for many of these counties. This may not be true for some terribly destitute areas.

But I think we have to have some sort of a framework on which we are evaluating these issues.

MR. SHEA: So Judy, is that the Wyoming view? Keep those residents in New York?

[Laughter.]

MR. SHEA: In past GME discussions, we've talked about is the Medicare program getting its money's worth in terms of the preparation of physicians for the Medicare population. I think it would be useful to look at the distribution issue similarly.

If we've gotten information on this in the past, I apologize, I'll go back and look. But if we haven't gotten like the geographic distribution lined up with the Medicare population, I think that would be worth doing.

Then on the telemedicine, Janet, do you know if the inclusion of this in the Balanced Budget Amendment was directly related to addressing a service need for the Medicare population in rural areas?

MS. GOLDBERG: I couldn't say.

DR. WILENSKY: I don't believe so. I think it was a broader rural issue, I believe.

MR. SHEA: It may have been the people who own television studios in New York, of course.

DR. LEWERS: Thank you. Just to comment on two things that have been said before I ask a question.

Joe, the other point you left out in your location or where residents stay, the majority of them stay in the region in which they train, a very high percentage of those.

The other thing, you talk about neurosurgeons, they're not really our problem. I mean yes, there are a lot of areas that don't have neurosurgeons and you anticipate the very high specialties being in more urban areas and have to be, but the problem is more of a primary care and the general specialties.

I think basically what we need to start with, at least I feel this way, is with a basis. And that is we do have an oversupply of physicians currently, and that it will accentuate in the next few years, and it includes all specialties and that includes family practice as a specialty.

There is going to be a workforce conference in March which I think will give us some information. As far as the time frame is concerned it has been moved up in order to meet our time frame so I hope that we can be there.

It's going to be convened by the AMA but it's a total group of people, all the people involved. I don't know the date, it's in March.

I have a comment first and then a question. We talk about telemedicine and I think we need to try to somehow evaluate where that is going to go and the problems, the pros and the cons of it.

Just for your information, a surgeon in Hopkins last week removed a kidney in Singapore while he was in Hopkins robotically. So if you think this technology is not moving, this is serious stuff. This capability is here and it's here now. I'm sure some of the people at Hopkins, and I can give you the people if you want to talk to them. But it opens more questions than it answers at this point in time.

I currently feel and have seen, in my travels around the country, what I think are market trends. I think we're seeing physicians move into rural areas because some of the areas that they have practiced in they just can't make it. There's one surgeon that moved into our area, a highly trained surgeon in the northeast in an area called Boston who wants to live in a small community, moved into our community, and simply found that he could not make a living and is now moving into another community.

We've had a lot of young physicians move into our area and when I've looked at their CVs, they're in an area three to four years and move on. A lot of that is due to the hospital involvement and the PHOs and hospital purchasing of practice. And where they get a significant bonus to come in and stay for an area and they get that and move on.

At some point they're going to have to put roots down, I think. But they leave, as Bill said, for educational reasons and lifestyle reasons, and particularly the spouse lifestyle reasons.

Do we have any trend data on that? Do we have any trend data on the bonus, once the bonus went in? Has that been monitored? What happened with the bonus? What are the problems with the bonus? Have we had the opportunity to look at that?

DR. WILENSKY: One of the problems has been the RBRVS has intervened and since one of the purposes of the RBRVS was to equalize payments so as to -- I mean, I don't know if anyone's looked at it but there were some major intervening variables going on.

DR. LEWERS: There are a lot of variables that have come in but there was a period -- and I don't know whether we could pick up some data on that. I don't think the bonus means anything, quite frankly. There are too many other circumstances for 10 percent to make a difference.

DR. MYERS: This is a big issue. There is an oversupply and this group, around these tables, has a responsibility to make some statements regarding what Congress should do. I believe very strongly that we need to take a much more in-depth look at the IMG portion of this issue and act. It would be very important for me to know, what is the reason not to decrease substantially the number of IMGs coming into the U.S. and look at ways to wean New York, Illinois, Pennsylvania from the IMG dependence that they have today?

It's going to be a very tough political issue but we've got to tackle it. I hope that we're able to get the kind of evidence, if there is a good argument to support sustaining in some way, that we'd like to see it because I don't know what that evidence is.

DR. WILENSKY: Could I ask you a question, just to follow up on this? We don't have to answer this now but maybe we could have people think about the IMG in the current context as one issue, where we are both subsidizing and frequently allowing, because of visa transactions, people who came in for a training position to come in on a subsidized basis and stay. But as opposed to saying not allowing them to come in and/or stay, we could consider allowing people to come in for training, as we do in other areas, provided there's somebody to pay and then not having the training.

I would just like us, as we are thinking about this, not necessarily to shut the door on the training but to say whatever rationale exists for subsidization by the taxpayer may not exist here and that our advice with regard to visa changes would be to not remedy that.

Again, I'm not suggesting we make this kind of decision, but I don't want to necessarily have people who are objecting either to the brain drain or the use of federal dollars to subsidize this group to necessarily say therefore we should shut the door on them. Because normally we allow people, if they're coming in for engineering or other areas, to come in if they have --

DR. MYERS: My second point was going to be we need to understand much more detail about the circumvention of Congressional intent with respect to the visas. I think we should know what the reasons are that the waivers are being granted and how they're being granted and the processes that are failing to control the return to the original country.

And finally, I wanted to agree with Judy on the issue of the rural.

And Joe, I don't know that there's any evidence to suggest that individuals in rural areas are less healthy as a result of the current distribution or maldistribution of primary care and specialty care. If there is such evidence I think we should look at it but I'm not aware of any today in the U.S. I think we might want to ask our colleagues at HRSA and other places whether they have some because if part of our task is to look at the geographic issue, I think we should try to base any decisions we make on clinical evidence that supports changing a policy based on including the health of the population at risk.

MS. GOLDBERG: Right now the MUP and HPSA data don't crosswalk, but with the new rule they might be able to crosswalk the data so that they can use health indicator outcomes, which currently are only used for HPSA designation.

DR. WILENSKY: There is some analysis, it would require -- I can send you some work that has been done, because these are all zip code identifiable, that you can do crosswalks but it's just not

as readily available with the analysis already being done. But you can reconstruct based on other data, I believe. At least some studies that have been done in the past that have actually tried to reconstruct shortage areas.

Let me just continue this point that was raised by Woody and Judy. I think we need to be clear that we should not look only at physicians, primary care or specialty physicians, by population but remember something that we've been hearing yesterday and then at previous times, which is there's a lot of geographic variation in terms of how health care is provided.

So not only do we have to look ultimately at health and access to services, but we need to remember that in different parts of the country we have different mixes of primary versus specialty care; of paraprofessional versus professional. We have a different use of nurse anesthetists and physician assistants and midwives and use of home care in very different quantities, in part reflecting different availability and different styles in terms of providing health care.

And that it's easy to look at these as much too sectioned. And if you have a different ratio of primary care docs to population or something else to presume that it is telling you something about care. And so we just need to take a slightly broader look at how care is being provided and, to the extent that we can tell what it means either in terms of health status or access issues, to make some statement about it, as opposed to saying if certain inputs that are used in some parts of the country aren't present in another part of the country that that means that we necessarily have a problem.

MR. SHEA: I just wanted to add, on the visa question, since Congress just enacted a very large expansion of the H-1B program, we might want to look at were there special provisions there that related to medical physician personnel.

Because we might see, in the future, a change in this where most of the visa growth has been in the training, the J-1 program. You might see it now in H-1B.

DR. WEINRAUCH: It has been in H-1B, both.

MR. SHEA: It has been? They just added 110,000 or 120,000 H-1 visas in the latest reauthorization, so this is potentially a very big source of additional -- not in the training area, but just additional IMGs.

DR. LAVE: These are physicians?

DR. WILENSKY: It includes them. I don't think it's limited to them but it includes them. It's professional.

MR. SHEA: It's all highly skilled

DR. WILENSKY: I think it had to do with some of the Y2K computer problems, but the question is who actually gets them?

MR. SHEA: There was a lot of the push behind it Congressionally was in the computer field.

DR. WILENSKY: That's what I recall.

DR. ROWE: Just one or two things. I don't know to what extent this is an issue, but I think that we have a view that the IMGs are foreign-born, foreign-trained physicians who are coming and moving into populations in middle America where they're competing with American trained physicians, et cetera. At least in New York, which is admittedly atypical, they're immigrant physicians serving immigrant populations.

They speak Urdu, as do all their patients. And none of the physicians that you're thinking they're competing with do, or want to, work in those populations. So I don't know whether that's an issue or not, or quantitatively how important it is.

But I'm struck that there are pockets of populations which are served by these physicians who these populations might not have access to effective care were it not for these physicians who are serving them.

I agree that there is a risk here. If we say there is an overpopulation of physicians, which I am prepared to accept, we can't at the same time say that those areas of the country that are below average in physician density are deficient. They may, in fact, be at the right number.

I don't think we can get good data on outcomes, but maybe we could get data on access, since the distribution -- it's more proximate between the number of doctors and the health outcomes, would be some data on access. So I'd like to see us try to look at that, if we could. Access to health care, as opposed to health status.

There were some suggestions that are people in rural areas sicker or healthier. I think it would be more interesting, short-term, to see do they have access to physicians and health care? And when we do that, we should include the VA and the DOD and the Indian Health Service or we're going to get some funny numbers in some states.

The other thing I would say is that I think that Gail's point is interesting about the taxpayer and should the taxpayer pay? I think we should be clear in our discussions that it's the federal taxpayer that we're talking about in that case.

It may be that the local taxpayers, in New York for instance, would decide that they want to pay for those residents because it's an important part of New York or Massachusetts or California. In which case fine, from your point of view.

DR. WILENSKY: And it was really just to not necessarily close the door if there was an issue about whether we should be federally subsidizing. That didn't necessarily mean to close the door.

DR. ROWE: I think we agree. I think the issue is not whether it's private payment versus government payment but whether it's federal payment versus some other form, which might be local government or private, would be presumably fine if that's what the city decided to do, or the state.

DR. CURRERI: Jack actually sort of said one of the things I was going to say. I'm a little bit skeptical of looking at these distribution figures, particularly in the rural areas. The reason I say that is what several others have said are perfectly true. There are some areas that simply can't even support a primary care physician, much less a specialist.

What those communities have done, to get the access you were talking about, is they provided very good transportation so that they can get access in nearby -- Texas is a perfect example of this, where there are many counties with no physicians but probably less than 100 citizens living in a very large county because they're big ranches. The state of Washington has done a whole lot of work in this in terms of transporting people over the mounts by air or helicopter or by fixed-wing air to Seattle.

So I think what Woody said and Judith said is probably true, there are many rural areas that on the face of it, as you looked at the figures, it would seem like they had less access to medical care because of a decrease in physicians when, in truth, what they've done is taken another solution and that is made access available by modern transportation systems.

So I think you have to look at that, as well.

DR. NEWHOUSE: Just to re-emphasize a point that Judy made and then apply it to what Ted said, that it's important for us to have a model in our heads of how physicians and other health professionals locate. Ted made the point that I left out, where you train matters.

It's one issue to ask and how many physicians of what type are in a given location. That tends to be governed by the what the demand is for physician services and amenities. It's another thing to ask -- well, given that there are probably going to be about 20 physicians in this place, who are those 20? That's where not only where you train but, for example, where you grew up matters.

It doesn't necessarily matter for the number 20. So it's a confusion between how many and who they are that actually comes out of some -- depending on how you do the analysis.

This also goes to Jack's point about the Urdu physician serving the Urdu population. This is a phenomenon of matching that goes well beyond that example. We know, for example, the

African-American population tends to prefer, on average, African-American physicians. That tends to affect who goes where in that physicians tend to match.

It's much less of an effect, I think, on how many physicians. It's really within the physician workforce who is where.

Then a caution on the underserved areas and health status and what matters. My understanding, Craig you may correct me on this, that some of the medically underserved area definition turns on health status. For example, if you've got a high infant mortality rate that gives you points towards being an underserved area; is that right?

MR. LISK: [Nodding affirmatively.]

DR. NEWHOUSE: So there's a tautological element in looking at medically underserved areas and health status.

Finally on Jack's point about access, which I thought was interesting. It's awfully hard to look at outcomes, look at access. Would you extend that to say look at access to the advanced practice nurses and the PAs as well as physicians? How would you factor in that aspect?

DR. ROWE: And mid-wives? I mean, I think so because in a lot of cases, the care that's available from the physician may be more technologically advanced than the care needed by the patient. So I would think that's reasonable.

I just feel more comfortable with that proximate relationship in looking at outcomes that might be influenced by -- you look at outcomes in the southwest and those are people who migrated into that area and they had health behaviors their entire life that influenced what kind of disease they're having at age 70. To try to match up the number of doctors in Tucson with the kinds of illnesses in Tucson, it just seems remote to me.

DR. WILENSKY: And besides, we can probably get the data.

[Laughter.]

DR. ROWE: And I think we can get the data.

DR. WILENSKY: I promised Woody and Ted they could say something, but we really ought to get to our next section.

DR. MYERS: Just very quickly, Jack I'm not so sure about your assumptions regarding the IMGs propensity to -- certainly IMGs are treating a variety of patient populations, as are USMGs. And certainly there is a desire to treat one's own community if that's possible.

But you seem to indicate that in New York there was some sort of an equitable distribution. There is not.

DR. ROWE: I was thinking, I don't know --

DR. MYERS: In Harlem and South Bronx there are a number of African-American patients who are not being treated by African-American physicians are being treated by IMGs in circumstances that are not necessarily positive.

DR. ROWE: I think that's right, Woody, as you know well. The example I had in my head, actually, was not the Urdu but is the Chinese population, which is almost uniformly cared for by Chinese speaking physicians, of whom there are very few that went to medical school with me. That's what I was thinking. But these may be just small subpopulations.

DR. LEWERS: Along that same line, I think this is an area perhaps we should look at, and there is data available and the Chinese population is a good example. In San Francisco, each of the Chinese physicians at the Chinese hospital there donate a percentage of their income to that hospital for indigent care to the Chinese. And I know that does occur in other areas, as well.

The Indian Medical Association in this country has fee clinics all over Massachusetts. They're developing more of them. They have a huge clinic in Illinois. They have data available and I think

that it would be worthwhile taking a look at this because many of the people they're treating would be on the Medicaid rolls, were it not for the services that are being rendered by these physicians.

So I think it's an area that we could look at and can, perhaps, get some data. I'll be happy to give you some names that you could contact.

DR. WILENSKY: Thank you. Helaine?

MS. FINGOLD: Good morning. You should all have a set of slides copied in front of you. There are two additional charts that you should also have. The translation from Excel to Power Point seemed to lose a few things so I fixed that this morning. You should have those in addition. The two extras will replace the two charts that are in the packet but you'll see that when we get there. That goes the same for the audience. I believe there are extra of the charts out there to replace the ones in the packet.

As part of the GME that Congress asked MedPAC to do, one of the issues that was specifically addressed in legislation was that MedPAC should address the extent to which Medicare and other federal payments are made for training in nursing and allied health professions and whether such funding should continue. I think that's pretty much the exact language from the statute.

The paper that you received and this presentation are meant to give you background to facilitate your consideration of these issues. We're going to discuss Medicare's policies on support for nursing and allied health education costs, amounts and characteristics of Medicare support for these programs, support from other federal programs, and we'll discuss some of the issues to guide the commission's discussion.

Some of the background things that the commission should keep in mind while we talk about these: should the federal government support nursing and allied health training? Again, this is probably best discussed within the context of also talking about the physician training support.

Should the support flow through Medicare as it does now or partially now, or through another mechanism? Should Medicare support flow only to hospitals? And if only to hospitals, only for hospital operated programs? Again, we'll talk about this a little later in the presentation.

And should the funding be reactive or directive to the workforce? In other words, should it follow where the people are? Or should it try and direct where we think there are shortages or needs?

Medicare reimburses hospitals' reasonable costs for nursing and allied health training programs. This is one of the last vestiges of cost reimbursement in the program. It's done on a pass-through basis. Again, it's outside of the PPS system. And it's based on the hospital's Medicare inpatient utilization rate or Medicare share. So they don't get 100 percent reimbursement of their costs, they only get that proportion that they have of Medicare inpatient utilization.

It does not include beneficiaries admitted in Medicare managed care arrangements. You should be aware the share only looks at fee-for-service care.

In the BBA of '97 Congress carved-out physician GME from the capitated payments made to managed care organizations but did not include a similar carve-out for nursing and allied health education.

By regulation Medicare's reimbursement for these programs is targeted. There are only specific programs that are indicated that hospitals can get reimbursement for. They're listed here on the slide. Intermediaries do have regulatory authority to consider reimbursing other programs. Some of the other programs that have received reimbursement are EEG technology, emergency medical technicians, histologic technicians and clinical pastoral therapists.

Note that things such as, as you were discussing in your previous sessions, physician assistants, nurse practitioners, nurse midwives and clinical nurse specialists, among others, are not included in this list and we don't have much evidence that they're being approved by the intermediaries under their regulatory authority.

Historically there have been several issues that have come up over and over again since the program was implemented in '66. Again, nursing and allied health reimbursement for the hospital's education reimbursement remains cost-based despite the fact that there have been changes in hospital reimbursement moving to prospective payment and changes in the way that the graduate medical education payments are made.

Again, this funding goes generally to hospital operated programs. There are some limited conditions under which hospitals can get reimbursed for costs of programs that they either operate jointly or that they do not operate but they incur costs for. But there are criteria attached to this and it is fairly limited.

Overall, Medicare's support for nursing and allied health programs, we estimate total '95 spending for both at $265 million. '95 nursing reimbursement we estimated $183 million and estimated allied health reimbursement at $82 million.

It's a lot of money but when you compare it to the physician medical education it's not a lot of money. It's small compared to physician GME. In '95 Medicare provided more than $2 billion to hospitals for direct medical education, money going to over 1,200 teaching hospitals.

So sometimes this area doesn't get as much attention because it's a small piece compared to some of the other bigger pieces, but it can be a significant piece for the training programs themselves, which we'll talk about in a little bit.

You can see the change, the trend in reimbursement from '90 to '95. There was a slight decrease in nursing education reimbursement, it declined by 1.3 percent. And
a increase in allied health education support, it increased by 23 percent.

This is helpful but it doesn't give you necessarily a sense of the wide variation there is in reimbursement among the hospitals. In '95 Medicare's reimbursement of nursing costs went to 326 hospitals out of a total of 5,872. That's 6 percent of hospitals received nursing reimbursement. The average reimbursement per hospital was $543,000 but those payments ranged from over $4.2 million to under $20. 10 percent of hospitals received more than $1.3 million and 50 percent received less than $400,000. So it's a pretty big expense.

MS. ROSENBLATT: Can I ask you a question? The under 20 it was $13 in the paper. How can any formula come up with a number like $13?

MS. FINGOLD: That's what our data ran. There could be questions about it. It's possible that they requested more money than that and that that's what it came out to be. I mean, a hospital will make a claim for costs but they don't necessarily get everything they claim for and they may have made mistakes. I mean, there's lots of things that could have happened that would affect the level of reimbursement. I can't explain the specific hospital that our data showed only got $13, but...

DR. LEWERS: This is nursing reimbursement, it has nothing to do with advanced practice nurses?

MS. FINGOLD: There is one type of advanced practice nursing that is eligible for reimbursement and that is the nurse anesthetists programs. The other ones are not eligible under the terms of the reg. Again, that's an issue that has come up over and over again and we'll talk about it a little more as we go along.

Again, there's large variation in the level of payments made for allied health. 592 hospitals received Medicare payments for allied health reimbursement. That
is 10 percent of all hospitals. The average in '95 was $133,000. Again, the range was over $3 million to under $10. Again, I'm not going to even try and explain that low number. 1 percent of the hospitals received over $1 million where as 50 percent received less than $58,000.

However, for nursing and allied health programs, Medicare supports only a small percentage of the programs that are eligible under the regulations or that are named in the regulations.

According to the National League for Nursing there were over 2,500 basic professional nurse training programs and 306 nurse master's level programs
in 1995. Our estimates show that Medicare provided support to only 10 percent of these programs.

As I think I'm going to talk about later, we can't define from our data whether Medicare support went to an advanced practice program versus a basic nursing program. The way that we get the data from the cost reports, it just says it's either nursing or it's allied health. So we can't tell you what kind of nursing program it is, nor can we tell you what kind of allied health program it is and that creates problems for us in understanding the lay of the land here. But again, we're going to talk about that a little more.

Also in '95, based on data from the AMA, we estimate that there were more than 2,500 allied health programs. In that year, Medicare reimbursed an estimated one-quarter of all the allied health programs. That's probably a high estimate on the Medicare side and a low estimate on the number of programs because AMA didn't have data on all the allied health programs that Medicare reimbursed. We might want to look at a wider range of allied health programs anyway, just to complete the discussion.

We also tried to get a better sense of how things are split out. We looked at the characteristics of hospitals receiving nursing and allied health reimbursement by a variety of factors including bed size, hospital size, rural/urban status, teaching status, and geographic location.

According to bed size, 90 percent of total nursing and allied health reimbursement went to hospitals with 200 or more beds. Of this, 88 percent of nursing went to the hospitals with 200 or more beds and 97 percent of allied health reimbursement went to those with 200 or more beds.

Rural/urban status, also 95 percent of the total Medicare reimbursement went to urban hospitals with the split for nursing and allied health right around there at 94 to urban and 6 for rural on nursing and 96 to urban and 4 for rural on allied health. So it's pretty close.

Also of interest, reimbursement went to over 650 urban hospitals representing one-fifth of all urban hospitals whereas reimbursement only went to 100 rural hospitals, representing 4 percent of all rural hospitals.

By teaching status, the majority of Medicare dollars went to teaching hospitals in '95, 78 percent of the total Medicare nursing and allied health went to teaching hospitals. 75 percent of nursing support went to teaching hospitals and 85 percent of allied health support.

By census region, you can see the largest percentage of nursing education reimbursement goes to hospitals in the middle Atlantic states, which receive 36 percent of total Medicare nursing education funds in that year. The middle Atlantic states include New Jersey, New York and Pennsylvania.

DR. ROWE: Just those three?

MS. FINGOLD: That's the three in the middle Atlantic of the census region divisions.

DR. MYERS: What percentage of nursing degrees are granted --

MS. FINGOLD: I don't have that in front of me. I can try and find out.

DR. MYERS: How well does that match?

MS. FINGOLD: It's kind of hard to track where the programs are versus where the reimbursement goes because some of it we can't tell what kind of programs they are by the Medicare program. I can see what I can try and put together. My understanding is that the programs are concentrated in New York, Pennsylvania and Ohio, I believe, but I'm not sure. I think I read that, that tends to be where a lot of the programs are.

On the allied health side, the largest percentage of allied health Medicare funds went to hospitals in the east north central region, which received 28 percent of the Medicare funds. The east north central is made up of Illinois, Indiana, Michigan, Ohio and Wisconsin. The middle Atlantic received 19 percent, that was the next highest, and then the south Atlantic received 14 percent.

That can at least give you a sense of where the hospitals are that will be affected by changes in this reimbursement policies.

There is a provision in the paper that talks a little bit about licensing and certification issues. And there was also an appendix attached to your mailing materials that Susanne put together on the licensing and certification issues if you have questions, but I'm not going to go over that in the presentation.

In terms of the workforce issues, in terms of supply and demand, the number of nurse training programs has grown overall. Between '76 and '96 there's been a growth in the number of BA and associate degree programs but a drop in the number of diploma programs. Master's programs have nearly tripled, from 106 to 306, between '76 and '95. That's 189 percent growth. Again, there was a 72 percent drop in the number of diploma programs.

The number of graduates has largely followed the same trends. Over the past two decades there's been 22 percent growth in the number of graduates of basic nursing education programs, again including the associates, the bachelor's and the diploma programs, rising from approximately 78,000 in '77 to approximately 95,000 in '96.

Within this, again there was a rise in the BA and a rise in the associate degrees but a 68 percent drop in the number of graduates of diploma programs. Graduates from master's programs have risen dramatically, increasing by 144 percent over this period. And there was a small drop in graduates from licensed practical nurse programs.

You should note that the number of nurse master's programs grew, along with the number of graduates, though for the most part, as we just said, a lot of the advanced practice nurse programs do not get Medicare support.

Regarding the allied health professionals, we don't necessarily have data on all of the professions that Medicare reimburses the training costs for. But overall it appears that the programs have increased between '90 and '97. The number of graduates has generally decreased during the '90s, except for some specifics.

You can see, for example, the radiography/radiation therapy graduates declined over this period by about 27 percent. Respiratory therapy graduates declined by about 26 percent. On the other side, clin/lab, clinical laboratory scientists and medical technologists grew by 16 percent and occupational therapy graduates increased by 28 percent.

DR. LAVE: Excuse me, are these the ones that we pay for or is this nationally?

MS. FINGOLD: This is nationally in the country, though these are the categories that Medicare pays for. There are so many categories that it seemed not feasible to address all the different types of allied health programs. So I tried to focus on the Medicare reimbursed ones.

The ones up on the slide are the extremes. The remainder that we looked at fell in the middle, most showing not much change over the period of time.

You should note, again, physician assistant programs grew by about 119 percent in number of programs and by 43 percent in number of graduates, again without Medicare support.

The Bureau of Labor Statistics projects continued growth in employment opportunities for nurses and selected allied health professionals over the next eight years. These range from a low growth of 13 percent for pharmacists to a high of 71 percent for physical therapists. Unfortunately, BLS doesn't track all of the allied health professions that Medicare reimburses. For example, they don't track demand for hospital administrators. And they don't separately assess some of the advanced practice nursing categories but include them all within the registered nurse category.

DR. ROWE: It wasn't clear to me from what you said, are these jobs or are these employed people? If this is a growth in jobs but the people aren't there to fill them then we have actually an undersupply.

MS. FINGOLD: They say it's a growth in employment. We had a discussion among ourselves whether that means demand or not.

DR. ROWE: Or supply.

MS. FINGOLD: It's a good question and I think we need to pursue that a little bit.

MR. LISK: I think it's a combination of both.

DR. LEWERS: In your oral you said physical therapists, it says occupational here. Which is it?

MS. FINGOLD: Did I say physical? Excuse me, it's occupational.

DR. KEMPER: Helaine, could you repeat the statistics on physicians assistants, the two you gave outside of Medicare?

MS. FINGOLD: The physician assistant programs, the number of programs grew by 119 percent. Again, it was during just the '90s. And the number of graduates grew by about 43 percent, though theoretically they're not reimbursed by Medicare dollars. Some of that is questionable, we don't necessarily know everything that's going on in the various intermediaries since they do have some independent authority to approve programs.

HCFA believes that they're not being reimbursed but we're not sure, in terms of what's going on out there.

DR. KEMPER: But that's without Medicare support?

MS. FINGOLD: That's without Medicare support.

Medicare is not the only source of support for these programs, as was mentioned somewhat earlier. CHAMPUS, the Veterans Administration, DOD and HRSA also provide money to these programs in different ways. The CHAMPUS resembles Medicare reimbursement. They reimburse hospitals for their reasonable costs but only at the CHAMPUS utilization rate. The VA and DOD generally give direct funding of training slots in their facilities but are not reimbursing services the way that the Medicare and CHAMPUS programs are reimbursing.

HRSA provides grant money and other dollars for nursing and a wide variety of allied health projects. Their appropriations, however, are small compared to the Medicare dollars going. Approximately for '98, $63 million for nurse education programs and $3.5 million for allied health projects. For these a lot of the monies are targeted so for the allied health, two-thirds of the money are going to continued previously funded projects and only one-third is available for new projects.

In conclusion, you should note that Medicare spending has been relatively constant. The nursing and allied health supports represents a small piece of Medicare dollars overall and only goes to a small percentage of programs, but those programs that receive it obviously are interested in keeping it and rely on those dollars. We've had visits from a number of different groups that are advocating to continue these funding programs.

MR. MacBAIN: A question on the allied health professionals. Is there any way we can get a sense of how much variability there is among the fiscal intermediaries and what Medicare is actually paying for?

MS. FINGOLD: Without doing a full survey, it's hard to say. There was a survey done in '88 by HRSA but it did not look at a statistically significant sample. They looked at a range just to get a sense of the variety that was out there. And I did mention the different types of programs that they found out were being approved. But they didn't look at anything that they could generalize to the greater population of intermediaries.

Without doing a survey, it's hard to say what's being done.

MR. MacBAIN: As I read through the materials this struck me as a component of the Medicare program that is haphazard, chaotic, unplanned, unintended, and it's just sort of monies flying out there.

MS. FINGOLD: Monies flying out, we don't know what it's going towards. I mean, the study in '88, HRSA says a lot of the money was going to the physicians' salaries, the teaching salaries for the people that are teaching.

But again, they didn't do a sampling technique. They just wanted to get a range of what it looked like out there so they tried to pick and choose. I think they chose a number of intermediaries and then looked at hospitals that those intermediaries dealt with. So you can't necessarily say that that represents the whole picture out there.

MR. SHEA: I thought this was a good presentation, as well was the last one. I thought it's been very helpful.

You raised the question here, which is also in your written document, about whether money should be directed to non-hospital programs. But I didn't see any question about whether there should be a targeting of the money for Medicare population designed programs, geriatric nursing or -- and I think the two are related because you can imagine potentially suggesting well, given the home care expansion, given the issues of long term care, maybe there should be some other kinds of facilities that maybe wouldn't have any interest in getting in the field, but at least potentially might be worth putting in the mix.

I think it's more of a question of targeted programs than facilities, per se. I mean, you could well do this training in a hospital based program obviously.

DR. LAVE: I found this extraordinarily interesting and very revealing, I must say. I have a couple of questions.

I can understand why it is that under a cost-based world one may want to cover these. I'm not sure why under a prospective payment system we do and let me try to articulate where I'm coming from.

First of all, as I look at these training programs, it seems to me that they differ in many deep respects, the same kind of issues, as the physicians. Both of them are quite short-term. I mean, the human investment of the person going through the training program is not that large. Actually it's a relatively good return to the person who is being trained.

So I'm really wondering why it is that we are paying for it this way? I think that in terms of who benefits, there is a question in my mind about -- that these are shorter training programs. I mean, we have a physician who's coming in with $100,000 worth of debt and we may want to think about them sort of bearing additional costs later on. But these are quite short-term programs and I'm not sure why it's different from any other undergraduate program, in fact, that we have. So I wonder whether we went to think about it.

The second thing is that I would like to know what the implication for having these programs is on overall hospital costs. And the reason that I raise this question is that this has to do with to what extent does having these programs interfere with a hospital's competitive position?

Some time ago we looked at a study and looked at whether having a hospital based nursing program led, on average, to an increase or decrease in costs. And we found that on average it led to a decrease in costs. The reason for this was kind of not surprising in that there's a fair amount of substitutability here between some of the things that the students can do and some of the things that the professionals can do.

And so if you sort of think about it, it's not surprising that having some of these programs could actually have an opposite effect on costs because you are using lower cost labor that can do some of the functions of the higher cost labor.

So I think that there really are very deep issues that are raised here. I think Gerry has raised a very good question and that is if, in fact, we want to have more people in geriatric nutrition

programs, or whatever it is, maybe we ought to target those very specifically because the cost of a mistake is not like the cost of a mistake in training physicians. I mean, these are short-term training programs.

I did read this and I know that HCFA made basically these arguments and the Congress and the courts said keep on paying for it. But it is really a puzzle to me, given the nature of these programs, the fact that the students do have a short-term program, it increases their human capital. Why, in fact, these are treated differently from all kinds of different training programs that we have for which the federal government does not contribute to their support.

MS. FINGOLD: Let me just add, some of what you're both getting at is what is Medicare's role versus what is the federal government's role.

DR. LAVE: No, what is a government role.

MS. FINGOLD: What is a government role, true. But some of this, like with the GME for the physician training, when this was instituted in '65 or '66, Congress said that this should be "in lieu of community support" with the implication that this was going to come in. So there's a question as to whether this is sort of the greater federal government support or this is Medicare support or what should this be or where are we going?

DR. LAVE: I guess I'm even puzzled about the community support on these kinds of activities. I mean, what is different between many of the activities that people engage in their own training in? What distinguishes that from some of these, so that they in fact would demand social support?

I guess that I feel quite differently about these than I do with the physicians because the nature of the training and the time period involved, I mean you're talking four years of medical school and then another five years. So you're talking about nine years of training basically. And for these programs, you're talking about two or three years.

MS. FINGOLD: Some of them are bachelors. Some of them are involved -- in the licensing certification you can see a little bit of the educational background, too. Some of them are included with bachelors programs. Some of the advanced practice nursing programs are beyond the basic bachelors programs.

DR. WILENSKY: Although almost all of them are excluded.

MS. FINGOLD: That's true, except for the nurse anesthetists, but that's another question that comes up, is should they be included? Medicare reimburses some of these practitioners as a direct for their services. It's interesting, only some of them. And a lot of the ones, these non-physician practitioners that get reimbursement don't get educational support.

So there's a question of whether that's consistent in the Medicare policy.

DR. WILENSKY: Again, the issue of what is the justification for the role, Medicare, federal government, any government. But that is, of course, a part of all of this, graduate medical education.

MS. ROSENBLATT: One of the things that struck me in reading the chapter is it sounds like some of what is in the current Medicare payment is out of date. And if we could do something about that, that would be helpful. I can't make a suggestion.

The other thing is I've got sort of a half-baked idea for a study, but there's all sorts of problems with it. It's sort of a take-off on what Judy said. I agree with what she said about this substitutability. If we think about what's the more efficient type of managed care program, what's the more efficient type of managed care or more efficient care? It's where you've got the right substitutions going on and you have care being provided by the right level of professional.

I was just thinking of a study which would compare say a well run managed care plan -- and that's where we get into the first question of what is a well run managed care plan -- and its use of allied health professionals versus medical professionals compared to fee-for-service.

Now Joe's going to say wait, that all has to be risk adjusted. And then compare that to the Medicare reimbursement. So that's sort of a germ of an idea that would obviously need a lot of additional work on what is the right analysis.

DR. NEWHOUSE: Actually, that wasn't what I was going to say. I was going to say something along the lines of Judy, but I asked myself is there any reason to think that the labor market for these people won't function reasonably well in the absence of federal support? I haven't heard an answer to that question that makes me say anything but well, it probably will function all right.

For one thing, the amount of federal support seems very small relative to the size of this market. So whatever the support is doing, it's hard to imagine that it's making a difference between correcting some great problem.

Then I would say, along those lines, I don't know what to make about all of the numbers about the growth of this and the decline of that and the projected employment. I mean, if the issue is what the federal support doing getting us closer to where we want to be? If the federal support isn't doing very much and if the market is functioning reasonably well -- and I'm willing to maintain an open mind about that but as I say, I haven't heard the case that it isn't -- then I don't know that these numbers help us very much.

MS. FINGOLD: It's hard to say on some of these issues because we don't have real detailed data. Our data doesn't break down --

DR. NEWHOUSE: I'm not sure if you had very detailed data how much that would help me.

MS. FINGOLD: I can't tell you the answer because I don't have it. I don't know what it looks like. That is a problem because you don't know what the money is going to do, how much money is going to which types of programs.

DR. NEWHOUSE: But it seems like a very modest amount of money in terms of how many people it's affecting relative to the size of these labor markets.

DR. WILENSKY: It can't be very much. So the basic functioning of what it going on in terms of training and the demand for people with these kinds of services can't be very much affected because of the amounts of dollars.

MS. FINGOLD: I see your point.

DR. ROWE: What's the total market for nursing, for instance, in the United States? It's 150 million a year or something like that out of what?

DR. WILENSKY: I'm sure there's somebody in the audience during public comments will tell us. And if not, we'll get it.

DR. ROWE: That's the question, I think.

DR. NEWHOUSE: Or just the total number of people whose training is being affected by this relative to numbers.

DR. ROWE: Percent of the total number trained.

DR. NEWHOUSE: We've already heard that it's not the baccalaureate programs.

MS. FINGOLD: An interest group came to speak to us and they estimated that for the nurse training programs they were getting about $5,000 per trainee.

DR. WILENSKY: But that's not for the baccalaureate programs, which is where all the growth has been.

MS. FINGOLD: Well, it may well be. It depends on the program. Some of the baccalaureate programs do get money depending on their affiliation with the hospitals. A lot of this is going to diploma programs because they are the hospital based programs and, of course, they're the ones that are shrinking and the number of graduates are shrinking.

So there's criticism, as Alice said, a lot of this is out of date. They're still focused on the hospital based programs where that's really not where the training is happening. In fact, the advanced practice nurses were not very developed, the field wasn't very developed, in '66 when the regs were implemented, as were the PAs weren't very well developed. So some of these practitioners are playing different roles, or more of a role today, than they were at the time that the policies were implemented.

DR. LEWERS: Just to extend it along the same line, I won't repeat. I think the data is very helpful in that it is an unbiased collection of information that many of us have seen over the years. I certainly appreciate that and am anxious to see it develop.

But if we could expand some of that along the line of are we getting the bang for the buck, I mean we hear a lot about advanced practice nurses with independent practice going into rural areas. Are they doing that? Oregon and Hawaii have those programs. I think that some evaluation of that, while a lot of the money doesn't go there still, I think if you're going to look at this that's an area that you might consider.

The massive growth in master's nurses programs, what are they doing with that degree when they finish? Are they going to bedside nurses?

MS. FINGOLD: We can get that.

DR. LEWERS: Are we seeing changes in the practice of nurses to where we have assistants that are doing much of the work that -- you know, I remembered when I trained with the nurses. What is that distribution into bedside nurses and delivering direct services to our beneficiaries?

So I think expanding some of that data, trying to expand into those areas, would be helpful.

MS. FINGOLD: Susanne points out that on
nurse anesthetists, they administer 65 percent of all anesthetics each year and are the sole provider in more than 70 percent of rural hospitals. So in that sense...

DR. LEWERS: And that's a debate for another day.

[Laughter.]

MR. MacBAIN: Just to follow up, I think, on some things Judy was saying. I'm trying to draw an analogy in my own mind between this and graduate medical education. With residents, we're paying the cost of licensed physicians who, at least after their first year, are actively providing care to our beneficiaries.

I can see that while it's a mixture of education and patient care, there's a clear patient care component there that I don't see in these programs. These are supporting the people in purely educational programs before they're licensed to provide care.

MS. FINGOLD: But they are providing -- some of this is clinical. This is the clinical piece. This is their clinical piece of training in the hospital, so they are providing care. Sometimes it's not direct patient -- I mean, for the clinical laboratory they're doing testing. So it depends on the nature --

MR. MacBAIN: I see a distinction there.

MS. FINGOLD: That's fair.

MR. MacBAIN: At least in my mind there's a significant difference between what you're describing and a licensed physician, particularly following the first PG year. I think it's easier for us to look at these programs are pure support for educational programs.

If so, then is this really the rational way to do it? When we support training for essentially the same licensure in one setting but not in another, when we're supporting training for one type of licensure but not for another for which there may be greater need, or not, we really don't know.

We're supporting the programs that are shrinking but not the ones that are growing. That suggests that the support isn't having a whole lot of effect anyway. It leads us into the question of just what is Medicare's role in supporting a purely educational program as opposed to a patient care activity.

DR. KEMPER: My question is for you, Judy. I understand the question about how responsive is the market to needs. I remember some research years ago about response of nurses to salary changes and maybe some cyclical effects there.

I didn't understand the distinction that you were making between physicians and nursing and allied health professionals in terms of how responsive the market was and whether the market would work, what the distinction was between those two groups. And we could take the Medicare support for physicians and divide it maybe into the direct support and the indirect support and draw that same kind of distinction between training and care.

DR. LAVE: I agree with you that there are -- I think that the issues are similar in kind but not in degree, if that kind of explains that. It strikes me that some of these are very short-term training programs, that people are investing in their own human capital, that they're not going into these programs with $100,000 worth of debt which is one of the things, I think, that happens with the GME people who are coming in when we're talking about should they pay for their own graduate medical education.

So it just strikes me that, in fact, that this is an educational program, by and large are educational programs, they're short-term educational programs. They lead to considerable increases in the human capital of the people who are being concerned. And it's not clear to me why, in fact, we are paying for that through patient care dollars. I mean whether or not that's an appropriate policy, let me sort of indicate that.

I think that to follow up on Gerry's observation, it does strike me that if there are certain types of individuals who are not available to train -- that we would like to jump start -- that it may make sense to support them directly rather than through patient care dollars, which I think is equivalent to Bill's comment.

The other question was really sort of a reflective question, which was that it seemed to me that the hospitals who are supporting these programs may not actually being disadvantaged in a competitive market if, in fact, these individuals are substituting in their training program for the higher cost individuals.

I think you can actually look at that by determining what the effect of having these training programs is on the overall hospital costs, controlling for other things. I think that that would be an informative thing to look at.

DR. KEMPER: I'll buy the effect on the cost, but I guess with respect to the training there's sort of an argument of bigger house, bigger mortgage. I certainly wouldn't argue that physicians aren't achieving human capital --

DR. LAVE: I'm not arguing that at all.

DR. KEMPER: It takes nine years and you get a --

DR. LAVE: As I said, it's similar in kind but not in degree.

DR. WILENSKY: We don't target on that basis. We don't only give GME to people who come in with $100,000 in debt.

DR. CURRERI: I think it's a mistake to say nine years because it's really 13 years. Here we're talking about college students.

DR. LAVE: And we are also giving it to everybody. At least at the current period of time, all of the physicians participate in this program, not sort of a random subset who seem to be being trained in this environment, which makes this even more of a puzzle.

DR. WILENSKY: I think that remembering that these are relevant questions for a broader discussion would be helpful but we don't have to make a conclusion on that today.

If there are no further questions on this session, I'm going to ask for public comments now, before we get to the last session of the morning, because it's of a somewhat more general nature of the discussion.

DR. ROWE: Gail, can I just ask one question, before we get started? I apologize.

We've heard that a lot of this money on nursing is going to diploma programs and we've also heard that diploma programs are being reduced rather dramatically. And then we see these data on the distribution are from '95. I want to make sure we don't get into a discussion about what to do about something which is of historical interested only.

I think it would be great if we could, when this is updated or written up, to get the freshest data we could on the -- if not the dollars, which you might not be able to get, if there's a continued change in the reduction of diploma programs. Because if so, then a lot of this might be moot.

MR. GUTERMAN: The one thing we do know is the total amount of money estimated to go to nursing and allied health has been fairly flat.

DR. LAVE: I have to point out that I come from a middle Atlantic state and I plan to go home.

MS. TAYLOR: My name is Pat Taylor and I'm a rural health consultant and I wanted to address some of the issues you raised in your discussion this morning.

The first thing I want to say is that geographic distribution is a problem that is attached to specific places. So when you look at averages, that is the average number of physicians per 100,000 in rural areas versus urban areas, that includes lots of places that are well served.

You know, there are big towns in rurals. There is towns 25,000, 30,000, 45,000. Some of them have big hospitals. But millions of rural Americans live in very small places and it's particularly those small places that have problems attracting physicians and retaining physicians.

So I think it would be helpful perhaps to you to have some maps that show, for example, the location of HPSAs. I mean, health professional shortage areas are real and they are not distributed uniformly across rural areas. So I would make that suggestion.

I also wanted to note about the physician Medicare bonus payment that 10 percent payment for Medicare patients where the services are provided in HPSAs. The figure I have seen is that rural physicians get about 40 percent of their income from Medicare. So another 10 percent of additional payment has to weigh quite a bit in terms of their total income.

So it may not bring physicians to rural areas, it may not be directly the reason to stay there, but if they don't have an economically viable practice, they won't stay there, and the 10 percent makes some difference in that respect.

The third point I wanted to make is about the J-1 visa waiver programs. Many rural HPSAs are only able to have a physician if they can get a J-1 visa waiver physician. I don't know how many communities that is, but I think we believe that all Americans are entitled to have access to health care and that program is very important for a number of rural communities.

MR. GRAEFE: Fred Graefe of Baker and Hostetler on behalf of the American Health Science Education Consortium. We've worked extensively with Helaine and it was a very fair and balanced presentation. Thank you.

The threshold issue for us is that the carve-out that was done for physicians in the Balanced Budget Act of '97 was not raised for nursing and allied health, and for us that's the threshold issue, number one.

Secondly, we have presented a joint proposal, which Helaine has, to the Medicare Commission to extend APN reimbursement to non-hospital settings, which we think will address many of the issues that you've talked about here today. Ann Roam is right behind me and she will, I know, want to talk about that.

But first is Dr. Jim Furenberg from Baton Rouge of our Lady of the Lake Hospital and College.

DR. FURENBERG: Thank you, Fred.

Just a couple of comments. One, just to show you the effect that the reimbursement has had on one institution, prior to the lack of reimbursement for Medicare HMOs we were receiving about $2 million a year in reimbursement for educating our nursing and allied health professionals. And by the way, we have both the associate and baccalaureate degrees in nursing plus six allied health programs, about 1,000 students. This past year we lost about 37 percent of our funding because of the HMO+Choice situation.

I might also mention that our hospital also furnishes clinical space for five other programs for which no reimbursement is received. So I think in a small way you see the effect that one institution has had because of the HMO+Choice situation.

MS. ROAM: Hi, I'm Ann Roam with the American Association of Colleges of Nursing. We represent the baccalaureate and graduate programs in nursing. I wanted to thank Helaine for doing a fine job on her presentation.

You know, it's certainly obvious, I think, to most people in the room that the Medicare education dollars for nursing are going in the wrong direction of what the Medicare beneficiary needs. It's going to programs that are decreasing in numbers, and so where really is it going?

One thing that is happening in nursing practice and nursing education that you need to be aware of is in a study that was conducted by Lewin in 1995 through HRSA, they came up with data that showed that the most significant factor that's going to affect whether or not we can produce these advanced practice nurses that are needed for folks is the availability of clinical sites. And indeed, the number and the access to clinical sites is decreasing as we move forward with the integration of health systems, downsizing of hospitals, the moving of training out into the outpatient community based areas.

AACN, in particular, really believes that if the flow of dollars is directed for training sites to the hospitals but beyond the hospitals, too, this will open up those clinical sites for training, allowing the continuation of the training of these folks. It does look like, on the slides, that we're doing quite well without this money because we're producing a lot of folks, but that could come to a screeching halt.

And as the Medicare population numbers increase, most of us needing these types of nurses to care for our elders and soon for some of ourselves, that's going to have a significant impact.

MS. MIRANDA: I'm Maggie Miranda from the Educational Commission for Foreign Medical Graduates. I just thought I'd give you a couple of additional bits of information regarding the J visa and the H visa.

As some of you know, the Educational Commission for Foreign Medical Graduates is responsible for managing the entry of the physician who's coming into residency training on a J visa. It is our function to respond to contracts that are submitted by the training programs in the United States, in which the physician who is being requested is to come in on a J visa.

There has been a very major increase in those numbers over the last 10 or 15 years. We've noticed it in terms of the demands that are made for that group.

The law specifies that the individual can stay in the U.S. for the period of time that it takes to complete a specialty residency training program, up to a maximum of seven years. Within that period, the physician may or may not request a waiver, of which the ECFMG has no role to play. However, there has been a fairly -- as has been commented on in some of the data -- an increase since 1994 in the number of waivers that have been requested. We don't track them but we also look at the same data that everyone else looks at.

It is probably closely tied to the fact that there was a provision in law back in '94 that permitted the states to request up to 20 waivers per year for physicians if they were to work in rural areas, I think has been commented on before. There's probably a direct relationship between the large increases since 1994 to the current period, in terms of those waivers.

With the H visa, of which again ECFMG does not play a role other than the fact that people have to be certified to go into residency training, that is what's called an employment-based visa. There was a ceiling
of 65,000 total national for all professions and non-professions to come into the U.S. That ceiling was changed just as Congress was closing to the 110,000 that was mentioned, of which physicians as professionals also have an option to come in.

That again, is a matter of the choice that is made between the training program and the physician as to which visa they may come in to for purposes of training. But essentially, it really is an employment visa and that's why there is a requirement of what's called a step three to have been passed. They do not need to be licensed, however.

MR. SHEA: Can people use an H visa to come into a training program?

MS. MIRANDA: Absolutely. That's why you see
that 9 percent.

MR. SHEA: Can you give me an example of where that would be the case, as opposed to a J visa?

MS. MIRANDA: Where the institution indicates, because they are the employer requesting the person. They have to meet certain employment-related requirements that have to do with labor. They have to present evidence that they have difficulty obtaining a resident through any other means. That's really the only difference.

MR. SHEA: But that's for a residency program?

MS. MIRANDA: Right.

DR. ROWE: Is that only for residents --

MS. MIRANDA: No, no, the 65,000, as I said, they could be physicians coming in to do practice in a rural area who meets all of the requirements, including having passed all of the steps, and to be licensed. It's an employment.

However, INS ruled that a training program can be considered an employer-based type of situation if they can meet whatever the requirements are for that particular visa.

DR. WILENSKY: If you don't mind answering questions?

MS. MIRANDA: I'm not a lawyer and I'm not with INS and I follow the same data and information you have.

DR. ROWE: Maybe Gerry and I can ask you one or two cases. So I need a chairman of neurosurgery and the current chairman of neurosurgery at the Radcliffe infirmary at Oxford is the guy I recruit because I think he's the best person or she is the best person in the world. And that's a British citizen and I try and get that person into the United States and I call Senator Moynihan or Senator Shumer or D'Amato or whatever, and I try and get a visa for that person to come into the United States and we say they're the only person in the world that can do this operation and we have a lot of this need in New York, et cetera.

What kind of a visa is that?

MR. SHEA: That's a special New York visa and one that's granted to only a few institutions.

[Laughter.]

DR. ROWE: Is that an H?

MS. MIRANDA: No. It would likely be, if you're talking about a chairman of a department, it would probably be an H. If you're talking about somebody who would come to fill one of your positions that you were trying to fill in your residency training program, it would more likely be a J. But that doesn't necessarily apply. It could be that it's an H if you want that person badly enough and

they're saying I'll only come if you get me an H because an H is an employment visa for five years that permits the individual also to request --

DR. ROWE: But a J is only for training, is that right?

MS. MIRANDA: The J as it's used in the specialty training is only for training.

DR. NEWHOUSE: The H visa is for five years and would permit what?

MS. MIRANDA: To apply for permanent residency immediately after entering the United States.

DR. LAVE: If I have a J visa and I've come for training and but we know a lot of the people with J visas stay. Is that where they get this special waiver from or do they get an H waiver?

MS. MIRANDA: No, if they're on a J they're are expected, by law, to return to their home country for two years prior to returning to the U.S. That's why some of this information about whether people do go home for two years or more and then return, because they're fully qualified to return to the U.S.

DR. LAVE: And then would they return on an H visa?

MS. MIRANDA: They can return on an H but only after fulfilling the two year requirement unless they get a waiver of the two year home requirement.

DR. LAVE: Now if I'm a J, and there was a woman from the rural area who addressed this issue. I have a J, I'm trained, I'm an IMG, I want to stay in this country. There's a slot available in a HPSA, so I get a waiver of my two year thing --

MS. MIRANDA: Through the request of the state agency.

DR. LAVE: Then what do I come in? Do I then count against the H requirement? Or do I sort of --

MS. MIRANDA: The latest wrinkle on this, a couple of years ago, as we know, is that they would remain on the J, which holds them responsible for returning home, until they complete a period of time that is required for them to work in that particular area. Then they can convert to an H. It used to be that they convert to an H immediately, but now they're held on a J until they complete whatever their contractual arrangements are for practice in that underserved area.

DR. LAVE: But then I can keep renewing that one, right?

MS. MIRANDA: That or in the meantime they may then be able to get an H.

DR. WILENSKY: After you've completed your contractual requirement in the rural area, you're off on your own?

MS. MIRANDA: Yes. Then you have to meet the requirements for the H. And then, if you want to become a permanent resident then you have to meet the requirements for being able to meet other permanent resident requirements, such as is there an oversubscription from the country that you're from? And if you're in that category then you're put on a waiting list. So people will be in different categories depending on what's happening in relation to the requirements for that visa.

DR. LAVE: It sounds so hard to say, but so many do.

DR. WILENSKY: And then again, there are a lot of waivers. We've created a major demand for immigration lawyers.

MS. METZLER: Christina Metzler, American Occupational Therapy Association. I want to thank the commission for addressing this issue this morning.

I'll just mention where occupational therapy seems to be having training problems primarily, and this may or may not be an issue for Medicare to address but certainly I would urge the commission to look at this, and that's in fieldwork placements for students. They are traditionally unpaid positions of three to six months duration. They've traditionally been in hospitals or rehabilitation hospitals or even skilled nursing facilities.

We're finding that there are fewer and fewer entities that are willing to take fieldwork students. There is a cost involved for these entities, and as the economics of the system changes, the Medicare payment system and other payer system, the consolidation of the numbers of hospitals and facilities. This is one of the bigger issues in training that we are facing, rather than at the school level or at the graduate level. So I just put that before the commission.

A related point is what one of the previous speakers mentioned, and that is the move to community based or non-hospital based sorts of service provision that would be the ideal place for some of our fieldwork students to be trained, but again the economics of that doesn't necessarily lend itself to many placements.

So this is a related issue to the education and an important one in our view, in terms of preparing well-qualified professionals who are able to begin work immediately at a professional level. Thank you.

MR. SHEA: Could I ask you a question? Can you say anything more, can you break down this cost factor? Is this liability insurance issues? What is the cost of the sponsoring --

MS. METZLER: I don't think it's necessarily liability, although that's certainly part of it. We've been having some recent discussions with Medicare about whether or not services provided by fieldwork students can be billed. It just takes time from professionals, for instance, in the skilled nursing facilities. All Part B outpatient is going to be moving to the fee schedule and there won't be very much time for the supervision and the instruction, and so forth, to be able to be provided.

I could see if we had some further figures on that. I'm not prepared with that kind of data today but I'd certainly be willing to investigate that and get back to you, so we can hone in on that question.

MS. TOWERS: I'm Jan Towers with the American Academy of Nurse Practitioners. There are a couple of things that I've heard said here that I would like to comment upon.

One of them has to do with the worth of giving money to nursing programs, et cetera, in relation to their clinical training for working with Medicare recipients. I think one of the things that I would hope that you would be addressing yourself to is how best to distribute these to a group of providers who do indeed provide many services to Medicare patients and who do need underwriting just as much as physician students do.

One of the other things that I would suggest is that there have been a couple of comments about limited time for educating nursing and allied health people. Just using our own example for nurse practitioners we're talking about a minimum of six years of preparation. This is very costly for our students, just as it is for physician students.

I think those kinds of things do need to be kept in mind, and I would hope you would try to address how you might be able to use cost effective quality care providers to help underwrite your Medicare expenditures.

DR. WILENSKY: Is there any further public comment from this morning's activities? If there was some confusion about whether it was only the last session we were inviting comment on or the earlier sessions this morning. But this was to invite public comment on any of the morning's topics.

It is just before noon and I think we're going to hold over the last session for the morning. We'll start the GME discussions in our January meeting with that topic. It's a serious issue and I don't think it is feasible to give it its importance in 10 or 15 minutes, which is all we could devote to it.

So we will, as we did with the international discussion this time, hold it over from the past session. The market changes and teaching hospital discussion will be the lead off on GME in our January meeting.

The commission will reconvene at 1:00 for PPS-excluded facilities discussion. Thank you.

[Whereupon, at 11:55 a.m., the meeting was recessed, to reconvene at 1:00 p.m., this same day.]

AFTERNOON SESSION [1:15 p.m.]

DR. WILENSKY: Let's get started. Stephanie?

MS. MAXWELL: Good afternoon. I'm going to talk about this year's potential recommendations for providers exempt from the inpatient PPS system.

First, this slide shows you the draft chapter outline. I'll summarize the first section quickly before moving on to the potential recommendations. As we know, there are five types of free-standing hospitals that are exempt from the acute care PPS. These include roughly 200 rehab hospitals, 200 long-term hospitals, 600 psychiatric hospitals, and 70 children's hospitals. About 10 cancer hospitals also are exempted. As you know, in addition to these free-standing facilities there are about 900 rehab units and about 1,500 psych units of general hospitals that are also exempt.

Since 1983, these hospitals and units have been paid their costs-per-discharge subject to facility specific limits established in a base year. Roughly half of the current providers were established before TEFRA was enacted and, per the law, their limit was based in their 1982 costs.

Providers that came online after that, however, have had some influence over their initial costs and thus over their payment limit. That element of control that newer providers have had in setting their limits has led to a fairly systematic inequity in the financial performance or the margins among the exempt hospitals and units.

The BBA tried to address both sides of the coin here. On one side, facilities were given the option to re-base to establish higher and more representative cost limits while on the other side those already with very high costs and limits are impacted by the national cap set on target amounts. The BBA laid out a longer term solution, too,
by requiring a PPS for rehab hospitals and units by
October 2000.

Long-term hospitals likely are next in line. Congress requires that the Secretary submit a report regarding a PPS for these hospitals by October of this year.

It would be most helpful for the chapter if we could focus today on the recommendations that relate to these PPS plans. This overhead lists four potential recommendation areas on this topic. Possible wording of the recommendations are listed on page three and four of the binder materials in this section. Those pages also note that in last year's report we had some discussion language but no recommendations concerning the rehab PPS and the long-term hospital PPS.

Before moving on, I'd like to quickly note the other potential recommendation areas in this chapter. Most of the draft text for these are in the chapter already. I'd like to table the presentation of these until January though because we don't have the final data for the hospital market basket and because we're still obtaining some information for the section on psychiatric providers.

Of course, I'm glad to take whatever comments you may have written already on the copy of your chapter, regardless of what section it's on.

The first potential recommendation is about the current rehabilitation PPS study. HCFA and its contractor are in the early stages of this. Right now they're figuring out which 50 facilities they're going to use. As we discussed in more detail in the September meeting, the overall study method is the same as the one used for the SNF PPS.

That is, HCFA's contractors will assess 2,000 rehabilitation payments using the MDS-PAC assessment tool and will record the resources -- actually the minutes -- spent by each clinician in caring for these patients. The next step will be to develop a classification system off of that MDS-PAC data that's predictive of daily resource use of patients. Finally, that staff time data will be used again to develop the payment weights.

The potential recommendation on this topic is supportive of the study because the staff time measurements will yield a brand new kind of useful information on these patients. Concern is expressed though about the adequacy of the study sample size. It's important for the sample to represent the range of patients treated in rehab facilities and also to allow for a sufficient number of patients within a group.

To give some concrete examples to this, recall that the SNF PPS study used about 7,000 patients and the FIM-FRG study used about 90,000. Given the number of classification groups within those two systems, they would have averaged about 150 patients per group in the SNF study and about 1,000 per classification group in the FIM-FRG study.

Actual sample size calculations, though, are derived from the amount of variation in the data you're looking at and from the level of change you want to be able to detect in the data. In addition, there are values that you plug in to basically get at how strong the study will be. Those are the significance in power calculations that you might have heard of.

Anyway, when you do the calculations using average Medicare rehab costs per day and costs per case, and when you apply the standard rules about the strength of the study, you find that the proposed sample size of 2,000 would allow you to create less than 10 classification groups.

On the brighter side, if you relax the rules about what size of difference you want to detect just a bit, you could get about 12 to 25 classification groups if you were looking at per case costs and about 25 to 50 groups if you were looking at per diem costs. The reason that is different is because the variation of per case costs and per diem costs appear to be different.

DR. ROWE: Stephanie, what is the percent difference you're talking about here, in terms of developing the power analysis? Are we looking at a 10 percent difference and you get 10 groups or a 20 percent difference and you get 25 groups?

MS. MAXWELL: When I said less than 10 groups
that was looking for a 5 percent difference. When I said 12 to 25 for the per case and 25 for per diem, that's the range if you're looking at 10, 15 or 20 percent difference.

These group numbers with the 10 or 20 percent difference do look better, of course, but I think that they're still a bit optimistic because you could expect the spread of the data to be larger in each individual classification group than the spread that I had in overall Medicare rehab costs to calculate these numbers. And again, the spread is key in calculating the sample size figures.

Finally, the potential recommendation and the chapter encourages HCFA to use data from its current study as well as from the prior work that it funded on this topic, namely the FIM-FRG system.

The FIM-FRGs and the MDS assessment tools have some components that are similar enough at this point that they can be easily crosswalked. Given the large number and the range of patients for which there are FIM-FRG data, one could update that data, compare it with the new study, and probably gain from using both of these development efforts to produce a more robust and equitable payment system in the end.

At this point, I wonder if you want to hold and have discussions at the end of the entire presentation? Okay.

In efforts to move to a more uniform payment policy across different post-acute care settings, HCFA is designing the rehab PPS using the MDS-PAC assessment instrument, as we talked about, and the agency is using a per diem payment unit which is also in the SNF PPS.

This overhead lists some of the key features of a discharge based rehab payment system. As you know, they're essentially under that right now because the TEFRA system is discharged based. A really straightforward benefit of such a system is that it does not encourage providers to run out the length of stay. The flip side of that, though, is the concern that patients would be discharged too early. That concern should be able to be controlled with a transfer policy and one would monitor the discharge trends in order to assess the value of the transfer policy.

For example, currently about 15 to 20 percent or rehab patients are discharged to SNFs. If the stays went down and the entry to SNFs went up, then one might re-examine the rates and the timing of the payment for the transfer policy.

And important, but more subtle, benefit though is that a discharge based system may help maintain the daily intensity of inpatient rehab, which is indeed one of the key differentiations of that and rehab in other settings. A per diem, by contrast, might set forth a cycle of longer stays and fewer services per day.

Finally, we've struggled over the issue of patient overlap between rehab hospitals and units and SNFs. We know that patients with the same principal diagnoses go to both sites. I've understood at least some on the commission, as well as some others, to believe that the functional levels and the comorbidity levels of patients do appear to generally differ among these different sites. But of course, the problem is that we can't quantify this yet. One could argue that we should have more information about the issue of patient overlap before switching from a discharge based system to a per diem system.

Long-term hospitals are on a slower path to PPS than are the rehabilitation hospitals and units. I want to briefly present the current status of plans, though, mainly because the Secretary is required to submit a PPS plan or some kind of status report to the Congress in October of this year. Not that there was a discussion of these facilities and some of the PPS issues in last year's March report, but we didn't have a recommendation.

HCFA likely will work toward a per diem PPS that classifies long-term hospital patients using the MDS-PAC assessment for its assessment instrument across site patients. Over the last few years, researchers have developed and proposed a PPS for these hospitals that is based on DRGs. What's different in this DRG system, compared to the acute care DRG system, is that the number the DRGs use is different and the payment weights associated with each of those DRGs is different.

As you know, we have not presented you with a detailed report solely on these hospitals and their patients or on the PPS issues specific to them. We'll do that in the future but now the two questions include whether you want to keep a basic discussion in this year's report as a lead up to the Secretary's report in October and whether or not you want to encourage providers to evaluate all potential PPS systems for the providers in this group, and also if you happen to have a strong a priori position about the payment unit, we could also have a recommendation on that score.

On to the final overhead. In past reports, the commission has discussed the basic similarity of some services across post-acute care providers, and yet the lack of information available to discern differences across the patients. The point of this section and potential recommendation would be to support the use of the MDS-PAC common data instrument. Such a tool would be very valuable even if the PPS systems implemented across post-acute care providers were not exactly alike.

Here we note examples where the data, taken even at basic intervals such as admission and discharge, would be helpful for quality monitoring and utilization review. Of course, the data set it

creates would help us evaluate and address several policy questions that are difficult to address in the absence of more information.

At this point I open it to you. Thank you.

DR. WILENSKY: Thanks. Comments?

MR. MacBAIN: Stephanie, I think you said there were about 100 long-term care hospitals?

MS. MAXWELL: 200

MR. MacBAIN: I imagine there's a fair amount of overlap hospitals and acute care hospital outliers; is that true? In places where there aren't long-term care hospitals those patients are being cared for somewhere, either in an acute care hospital as an outlier or in a SNF, so maybe that's a question I should ask, is where are they getting the care? How is it being paid for in other settings?

MS. MAXWELL: Actually, we have a plan to try to track this in a summer data initiative. However, when we asked long-term hospital clinicians this who, in fact, have worked in other facilities before working in long-term hospitals, their feeling is that patients generally merge through a variety of different settings and there would be PPS hospitals and possibly PPS outlier probably going to a SNF, having a greater number of interruptions back to hospitals during a SNF stay to receive services that a SNF isn't able to provide but a long-term hospital with its hospital capabilities could provide.

Long-term hospital clinicians also state that they have an orientation toward allowing longer term stay patients in the PPS but basically a higher level of clinical services they can provide than SNFs and it provides an opportunity to kind of stabilize patients and return a level of function that, when it happens so efficiently in patients that might not have an opportunity to have those hospitals.

That's again something that we don't have data on and to the extent that we can track and kind of compare different sites as they move through, it's something that we're going to look at.

DR. ROWE: Stephanie, do you hear from them when you talk with them about palliative care, care at the end of life, as being a major focus of these facilities?

MS. MAXWELL: I have not asked about that. Probably in public comment, someone might be able to direct an answer to that.

DR. ROWE: I'm talking about the so-called long-term care hospitals or chronic care hospitals. Some that I know of seem to specialize in care at the end of life or palliative care, which is really short-term, but it's a different set of resources that are often applied to the needs of the patient. I just wondered whether that was something that had come up? No?

MS. MAXWELL: I can't speak to that.

DR. WILENSKY: They're not officially hospice, they're just providing similar care.

DR. ROWE: If you have a patient that's in the terminal phase of their illness, oftentimes one can transfer the patient to a chronic care hospital. It gets them out of the acute care, they need more care they can often find available in a SNF. And that's my personal experience, at least as a physician not as an administrator.

So I'm just wondering whether or not that's a component. Maybe some of our colleagues here today, who represent these institutions, can clarify that for us.

DR. LAVE: This may have been in the paper and I didn't see it, Stephanie. The question that I have is do the long-term care hospitals, the rehab hospitals, currently complete the MDS so that we have MDS data from them? Or is that a proposal that Medicare is having?

Where that was leading me to is that if you take the highest degree RUGs, would there be an overlap between the rehab RUGs in the SNFs and the rehab RUGs, the RUGs that would be created in the rehab centers? I guess I'm still a little confused about if I have a nursing home which is engaging in rehab in the higher level SNFs, would that be comparable to the kinds of care that the rehab patients in rehab hospitals are getting for patients who would be classified into those RUGs?

The same question on the long-term care, that is that the SNFs, there is some inhalation -- if I remember the long-term care data that we had before about what was going on, there was a significant number of patients who were on respirators and various other things. And yet there are some respirator RUGs. And I'm just kind of curious about whether or not we're talking about the same patients if we have the data to look at it?

MS. MAXWELL: I'll take the first question about the MDS-PAC. As you correctly assumed, it is not in the current rules or requirements for rehabilitation PPS.

DR. LAVE: So we don't have that data?

MS. MAXWELL: Right. At this point there is available and being analyzed data off of MDS II, which is the version that's actually being used in the SNF PPS. It's the version that basically doesn't have very much about functional status and it doesn't have as much about diagnoses. It doesn't get to some of the ancillary needs as much as the current MDS.

But anyway, about the issue of common data collection, there is data on the MDS II that's being analyzed now. Basically, that was the first stage of developing this MDS-PAC which was tested in about 50
SNFs, 50 rehab hospitals, and 50 long-term hospitals.

As the instrument is being finalized the data will become available but is data that will more likely discern the differences because the tool will be better. Obviously, HCFA is planning on having the data on all of the facilities because of having that being a basis for their PPS. But even if didn't go through or even if there was some delay in law, you would still at least have this field testing data on those topics at this point.

About the issue about rehab RUGs and the overlap with SNF RUGs, right now there are 14 rehab RUGs within the SNF system and they're based on minutes of therapy time that you get. You go something like, if I remember right, from about 45 minutes for the lowest classification to something like two-and-a-half hours for the highest classification.

In rehab hospital you are supposed to have a minimum of about three hours, so not that they would use minutes as a classification, but you can kind of get a sense from the standardized payment weight that would be used, and possibly the weights among the different groups, that you would kind of be looking at a band on top, even if the classification elements were different.

For example, if they used diagnoses and some level of functional status to create the groups and had nothing about time in the classification group, just given the standardized payment amount that they were going to develop and weight for the different groups, you can envision in that sense that it would be kind of a band over the SNF system.

DR. LAVE: That would help.

MS. MAXWELL: There's kind of a similar circumstance, just substitute the kinds of services as you mentioned for the long-term hospitals versus some of the SNFs that address more medically complex patients. There are some facilities that own both SNFs and long-term hospitals that care for, as you mentioned, ventilator patients. I would think that the standardized payment amount would be higher for the long-term hospitals given their cost experience that they've had so far. Coming off of that would be just some of their requirements as hospitals rather than SNFs.

DR. NEWHOUSE: I think there is two fairly large issues here that are related. One has to do with whether we want or think a consistent basis of payment across different sites of care. The other is, whether we do or not really, what the basis of payment should be. Let me speak to both those points.

In general, we struggled yesterday with the hospital outpatient department, in terms of could we get consistency. Here, I think the argument is well, if you have the same patients that go to different places, SNF, rehab, in some cases long-term hospital, shouldn't the payment system be neutral? Well, yes, if you could figure out what a neutral payment system was presumably.

But a different basis of payment seems almost guaranteed to be non-neutral. That is, if I pay -- and I know I'm going to offend my friends in the rehab communities since they've been paid per case and developed FIMs and FRGs -- but if I paid rehabs per case and paid SNFs per diem, I have an incentive to put my short stay patients in the rehabs and the long stay patients in the SNF.

And while I may kind of tend to do that anyway, I don't know that the payments -- there shouldn't be, it seems to me, incentives in the payment system to do that, that we've just sort of constructed.

And I also don't know that if you look at the empirical degree, if you try to establish the empirical degree of substitution, however well you could do that, that you would shed light because the payment system is actually going to presumably affect the actual patterns you observe. And if you set up the payment system with strong enough incentives to put people in one place, that's where you'll find them.

The second point is well, if you're going to be consistent, or even if you're not going to be consistent, is per diem or per discharge better? And my thinking about this tends to come down on the per diem side. There's actually a statement that you have in here that says the product is the discharge and so we ought to pay for that. I'm not persuaded by that logic because you could equally say the product of the SNF is the discharge.

It seems to me you want to pay by the discharge when there's a fair amount of consensus on the bundle of services that constitute -- that you're trying to deliver in that discharge and that you can kind of monitor that you actually get that bundle.

It seems to me that there's several problems, or at least two main problems with saying that that holds here. One is that the patients just inherently vary and in ways that the case-mix system will pick up partly, but I don't think it will pick up all that well. The second, and this is kind of a related point, the patients come into the post-acute facility at different stages. That is, they've stayed for varying lengths in the hospital, and so where they are in their course of recovery varies.

So for both of those reasons, the per diem seems like it's going to work better in terms of adjusting for the natural severity that's there. Now whether it should be a capped per diem we can get to when we talk about SNF.

But you do deal with this point at one point in the discussion where you say a transfer policy could potentially deal with premature discharge which would be the concern here. I have two concerns about that. One is you say the provider would receive a reduced payment if they were discharged prematurely. Well, how would we know if it was premature or not? I don't know. That's just left open.

Second, even if we could determine it I am, at least, uncomfortable with a payment system that is kind of setting up incentives you don't want. That is, even if you're going to put on a regulatory system that is going to try to judge premature discharge, it seems to me you would want to try to get the financial incentives working along the same path as that system you want. You don't want the financial incentives going in the other direction.

But we ought to see what amount of agreement there is, because this is, I think, a first order issue with respect to what we're doing with reimbursement of these institutions.

DR. KEMPER: I wanted to comment on three issues related to the rehabilitation hospitals. First of all, it seems to me that it would be useful to have a recommendation in here about HCFA's establishing the basis for monitoring quality and -- I don't know what you would call it exactly, but appropriateness of admission regardless of what payment system is actually put into place.

It would be useful in the report, if there is time to do it, to say something about what quality monitoring possibilities there are in the area of rehabilitation. My understanding is there's a fairly well developed set of data and so on that would make it possible to monitor quality.

But I think that has such a -- monitoring is very important to deal with the issues of incentives that if we go one direction we might lead to stinting and going the other direction might lead to extra care or unnecessary care.

The second comment is I would argue that the product unit here is the rehabilitated patient and that takes me to think in terms of the discharge as the unit of payment. But really the conceptual notion is that what you want to pay for is the rehabilitated patient and if there are good clinical guidelines that call for more rehabilitation early in the stay, intensive efforts at the beginning and that leads to different costs over the course of the rehabilitation, then that incentive is correct.

Yes, there's a risk of not providing enough rehabilitation, and that's why I think it's important to have the quality monitoring there. But to me, conceptually, you really want the rehabilitated patient to be what you're purchasing.

I certainly agree with Joe and it's consistent with much of what we've argued in other areas about consistency across settings. It seems to me, in this case, that there are two ways to go. One is to wait and see and monitor the extent of substitution that we see across the SNFs and the rehabilitation hospitals because I think that there is an argument that the patients really are quite different. There's certainly the potential for substitution, but that's something that could be monitored.

The possibility is, in the longer run, if that inconsistency is a serious problem, to either split off the therapy that's done in SNFs and try to figure out an episode or discharge based payment for the set of patients that match the rehabilitation payments, or even go to discharges for the SNFs. But I would argue wait to try to fix that in a potential substitution and unequal incentive across the two settings.

The third comment really is more of a question. I know there's been a lot of research funded by HCFA and done by Rand over a great many years with fairly sound and I think very successful results in terms of ability to predict resource use, even though patients do vary a lot. The predictive ability, if I understood your materials that you presented in other rounds, that the FIM-FRGs really predict quite well.

So I guess it would be nice to see some analysis of -- I mean, you really talked about two alternatives here, the FIM-FRGs and the MDS-PAC. It would be nice to see some analysis comparing those two and how well they do at predicting costs under the two.

I guess that's really my question, is how much we know about how the two alternatives work and how well they predict and what the incentives are? So maybe you can comment a little about that.

MS. MAXWELL: Your comment about knowing fairly predictably the length of a stay or the research use associated with payments, that speaks a little bit to your concern about the transfer policy. If HCFA could, over the last decades or so worth of data, they could see trends in length of stay by different discharge and the kind of functional level groups that have a sense of how you should structure a transfer policy.

DR. NEWHOUSE: How would you know what you wanted?

MS. MAXWELL: I would think you wouldn't want much of a change from what you have now.

DR. KEMPER: Do you want to comment on the two alternatives, the FIM-FRGs versus the MDS-PAC?

MS. MAXWELL: We can't do a comparison now because, in fact, we don't have access to the data that developed -- we don't yet, at least, have access to the data that led to the creation of the MDS-PAC, in other words, the field testing and the rehab hospitals, which is the first data source that you could use to kind of crosswalk and get a sense.

At this time next year, I think we could have done that.

DR. LAVE: I'll make a bet. My guess is that the MDS-PAC, in terms of proportion of costs accounted for, will explain a higher proportion of the variation than will the DRG-based FRGs only because the major factor accounting for any costs is the length of stay. So if you've got a system which accounts for the length of stay in it, my guess is that it's going to trump a discharge based system in terms of accounting for differences in the average cost per case. That's just sort of a mathematical truism.

DR. KEMPER: Wait a minute. If we're paying on a discharge basis, on a per case basis, how can you put length of stay in the --

DR. LAVE: No, no, but if you wanted to compare the differences in the cost per discharge accounted for by the MDS-PAC system versus the FRG system, all I'm saying is that the answer to that question is going to be the MDS-PAC system will dominate. But it's not clear to me that you want to make your decision based on that, only because the length of stay is a major predictor of costs.

But I have another point.

DR. KEMPER: But I don't understand if you put -- you can't put length of stay in the classification system if that's the basis on which you --

DR. LAVE: No, but I thought the question was if I take a data system and I say which of these two explains a higher proportion of the cost per discharge, the FRG system -- that's alternative one and we'll say that accounts for 60 percent -- or the MDS-PAC system? And I would say that whatever the proportion of the cost per discharge that is accounted for by the FRG system, that the MDS-PAC system is going to account for a higher proportion because it's a per diem based system.

DR. KEMPER: You've got to compare predicting episodes or discharges with predicting discharges or predicting per day with predicting per day. I mean, you've got to have an apples to apples comparison.

DR. LAVE: That one I don't know.

DR. KEMPER: Actually, just a comment on the draft is there really --

DR. LAVE: You're right.

DR. KEMPER: Before we leave that, it concerns me that at this point in the process we can't have a comparison of the two systems to think about what kind of recommendation to make in terms of the alternative payments.

DR. NEWHOUSE: Which two systems, FIM-FRG and MDS-PAC?

DR. KEMPER: Right.

MS. MAXWELL: That's right. You can compare the conceptual differences, for example obviously the payment unit. But we can't really speak to the classification criteria.

One comment about your question, Judy. You probably remember a pretty long and information packed paper we had in the September meeting that compared and went over what we knew about the FIM-FRGs versus the RUGs system. There are some researchers at the University of Colorado that ran the FIM-FRGs on the SNF patients and ran the other way around.

Basically, each system didn't work very well on the other patient group, partly because they in fact were not -- they weren't set up to model that. But the length of stay was a big issue with regard to the rehab patients. Resource use and length of stay are quite correlated in the rehab population and not so correlated with the SNF population.

It is the SNF maybe if you start dividing out the patient population, like what you were saying, maybe a shorter term --

DR. LAVE: That's where I was coming from in terms of the RUG, was that you were looking at whether you ought to take some of the patients who were admitted to the SNFs for rehab and compare them with the rehab patients.

But I have another --

DR. WILENSKY: Wait, I'm sorry, we have too many people in between.

DR. LAVE: I'm sorry, I thought I had a question and we went back and forth and I didn't get it in.

DR. WILENSKY: Are you still continuing on this issue with --

DR. LAVE: Well, it's has to do with the same point, with Joe's point with transfer. That has to do, it's a question really for Jack. How difficult is it for a senior to be transferred -- how unsettling is it for a senior to be transferred say from a rehab to a SNF if the feeling is that they will be discharged from the SNF? Is this a disruption that one should be concerned about? Or just simply a financial transfer, which is the way we're considering it?

DR. ROWE: May I try to respond to that? I actually had this discussion, I'm a member of the New York State Hospital and Review and Planning Counsel and we had a discussion on this issue last week because at one of the chronic hospitals in New York state, Helen Hayes Hospital had asked for 25 SNF beds and the rationale was they wanted to move patients from different levels of care within one institution rather than relocating them to another institution because of the disorientation and the adverse effect, et cetera. So we've discussed this very recently.

I believe that for many, but not all, patients there is a very significant disadvantage to relocating them to a new institution and a new facility. The typical example for many of us is you have an older frail parent who has say a mild cognitive impairment and there are four children and they pass the parent around every three months or something. Live with my sister for a while, then my brother, et cetera.

The parent never figures out where they are. It just takes a very long time for people to get comfortable and function at their best in an environment. And there is substantial concern that shifting patients from one location to another because of differences in the kind of care that they need, from an acute hospital post-op unit to a less acute unit to a rehab facility to a SNF is associated with reductions in the effectiveness of the care.

That's a clinical observation. I don't know that we have data to support that. But that's the answer to your question.

And I would say that the people at most risk for that are the most frail with the most comorbid conditions and the highest prevalence of cognitive impairment. So you could actually identify the people. It's not all old people, by any means.

DR. LONG: I just wanted to raise a couple of questions in the area of the psychiatric facilities. It appears to me that we're dead in the water here. HCFA's not doing anything. We really aren't saying anything different than last year so far, although I note that you're going to have some additional things by January. There doesn't seem to have been any major efforts out there to develop new classification systems for the last six or seven years. And on the political front, the one proposal didn't get out of committee.

So I'm not sure where we are or what we ought to be doing here, or even how important it is. I don't know what's happening to psych costs. I don't know what's happening to psych volume. We had some discussion yesterday that suggested in the area of prescription medications that maybe there are more admissions in order to get them on the inpatient side, but I don't know what's going on.

When I look at our recommendation, which is last year's recommendation, I'm not sure what we mean when we say look at further classification systems. Further beyond what? What kind of improvements do we think are possible and how much energy and political points do we want to expend in this particular arena?

MS. MAXWELL: Well, can I table some of this for January? I can have numbers at hand about the length of stay and costs. I mean I can tell you now, in the recommendation, the discussion last year kind of toned down a request for developing a PPS down to further improvements. And I think,

if I remember the transcripts correctly, it was mainly recognizing the time line of all the different new systems that HCFA is doing.

I think the goal was to not expressly call for a PPS immediately when we hadn't done a huge level of research on the classification systems available, or classification research available.

The psychiatric hospital trade group was fairly happy with TEFRA for several years, but given the changes in basically the reductions in the payments off of the BBA, it doesn't look so good anymore and they're interested in a per diem PPS. That is what was in the bill that's been crafted in the House.

I don't have a sense of what kind of support there was for that in the committees at this point. I can come back with more.

DR. LEWERS: My concern is the rehab hospital, obviously for personal reasons, having been there. There's a changing structure and I'm concerned that we don't in some way stimulate the shorter stay that's being forced on some patients today by our reimbursement mechanism. I hope we keep that in mind, that we're being pushed to get people in and get people out.

There's a changing structure within that system, and that is they're getting patients earlier. They're getting patients who are coming in, discharged because we're decreasing the length of stay on one facility and putting it on another facility. When I went in I had open wounds, I had a closed head injury. And my first week in rehab was totally different than my second week.

Somehow we've got to keep this in mind and make sure that not just shorter stays but appropriate stays, and how we determine that. I don't have an answer to that.

RUGs, to me, are floor coverings. I don't understand all that. I mean, I try to but I really seriously don't. But I notice in the long-term hospital you state that what HCFA prefers and what the providers developed. Have we talked to the rehab facilities as to what their recommendations are to cover this changing structure? Do we have any idea of what they might recommend that would help us in trying to do appropriate stays but yet control the costs that we have to do and are directed to do?

MS. MAXWELL: Two parts of the answer are first, I actually haven't talked with them about your first point of patients actually coming in with a lower functional level or lower capacity at first. Although I have heard that also, particularly in some markets where capacity in rehab hospitals isn't super high. Doing that is a mechanism to compete with SNFs that, in fact, moved in to kind of take some of the rehab territory. So I have heard that same thing.

But as far as the specific goals or positions of the rehab industry, off of that issue we have heard and they can, in the public comment, add if my comments aren't correctly characterizing their statements, they strongly prefer the FIM-FRG system and they prefer a per case system.

With regard to HCFA's study, they prefer that the resources devoted to the study be altered so that the measurements in the 50 facilities of the 2,000 patients are, in fact, capturing use of ancillary services which would get at some of the issues that you're talking about. The level of ancillary services, particularly in drugs and extra services that you might not traditionally think of rehab hospitals, is a service that wasn't really examined and developed within the FIM-FRG system, given the cost report data and the MedPAR data that they had to develop it.

So in a way, I think their goals for the system and for integrating HCFA's work, in a bit, gets at what your comment is about coming into the rehab facilities earlier.

DR. WILENSKY: The real problem, Ted, that I think we're grappling with that Joe raised earlier, is the consistency issue across payment. The FIM-FRG was developed for this area. We've had the problem that the RUGs seem to work best as resource utilization grouping and nursing homes. It doesn't seem to cross over into another facility. The FIM-FRG seems to work best in the rehab.

But these classifications aren't iron clad, easily predictable going in and we see that patients, in fact, sometimes are in one or in another, which are not obvious they would have been in one

versus the other, or they go from one facility to another facility. And not having consistent classification payment schedules sets up at least the potential for incentives that are responding to the payment, the payment unit, the payment incentives. And that's the struggle that we continue to deal with.

If it was possible to pull up a patient and say this patient would only ever go to this kind of facility, then the fact that we had inconsistencies in the payment across units wouldn't make so much of a difference. It's the struggle that patients are sometimes in one and sometimes in another. And sometimes in sequencing of going from one to another with what looked like a roughly similar illness or recovery stages that makes this problem so difficult.

DR. LEWERS: I understand that but when I went into the unit and they had my admission conference they said you're going home in 10 days, and they gave me the reason why. They said you'll be able to do this, this, and this, and in 10 days you're out of here.

I went home on the 9th day because I was tired and I didn't want to stay another day. But they have systems of predicting this that are very accurate. To me, yes, I know you've got to classify and I know every single patient's different. But I don't want us to put some payment system which is going to penalize a major portion of the patients who are in those facilities.

But they do have mechanisms of doing this and they're quite good at it.

I haven't heard where they're coming from in that element. That's my concern.

DR. WILENSKY: We'll make sure that if there's more information we can get you, in terms of what they've suggested within this issue.

MS. NEWPORT: On the second to the last possible recommendation, talk about the quality collection of data, at least nominally stating, in effect, that you'd have a common data instrument and they could infer some quality from that.

I think on one point that's right. I would urge some caution, though, in part for all the reasons articulated here, is that we seem to devolve a lot to raw data as indicators of quality. I would submit, in this area in particular, that especially for an elderly patient who physically should maybe benefit from some rehab, but has some dementia, that becomes counterproductive because they cannot handle the rehab. That's just one example.

So I think we need to look at some kind of chronic care case management process, but in saying that that kind of works against what is your last sentence in your recommendation, in your summary, which is minimize the burden on providers.

I think that all of this is notionally very good, but I think it doesn't get to, in this area, the quality of care. You get to care being provided, but ultimately outcomes may be substantially different and for a variety of different reasons. I think we've all articulated that to some level, but I think that there may be some more exploration that needs to be done in terms of the utility of data and what it really means in certain areas.

Services are being rendered but the outcome may be marginalized by lots of other things.

MS. MAXWELL: Do I understand that you'd be interested in us kind of exploring the issue of a case manager across care?

MS. NEWPORT: Yes, and maybe just talk to a few people. In the Balanced Budget Act there was a requirement on managed care to have case management for some chronic cases and talk to the people about the challenges of implementing something like that, because I think there are some. That would be a place to start, at least broadening the depth of our knowledge on what is a real good quality monitor in this area.

MR. MacBAIN: I'm tempted to start by noting that a very short time ago this room was too cold and we've now fixed that problem by replacing it with another. We may end up doing the same thing with the exempt facilities.

In talking about the per diem, the last time we visited this issue I asked a question and got a very revealing answer on something I didn't know. In a rehab hospital the tendency is for the cost per day to go up over the course of a stay, rather than have the cost front loaded as in an acute hospital that is paid -- and Ted, I think, confirmed that. As patients get stronger, they can tolerate more aggressive therapy, more hours of therapy. And so it's the last days of the stay that may tend to be the most expensive.

Which means, putting that together with a per diem, that the incentive in a per diem system could still be to shave off the last day or two when the marginal costs might be considerably higher than the marginal revenue.

I don't know if it's better or worse than a DRG-type system but I don't think a per diem automatically solves the problem of a stay that's too short. The fact that the industry has some enthusiasm for a per case or a per discharge payment system makes me tend to want to take a serious look at it.

The other concern, we've been talking about the differences in facilities between a SNF and a rehab hospital and the fact that different payment systems seem to fit the different facilities better. But is it the facility or is it the characteristics of the patient?

I wonder if we were to look at the things that distinguish a SNF patient who qualifies for the rehab RUG as opposed to the other SNF patients, is that a strong enough differentiation that we could say with confidence that we could have a facility being paid on two different bases, one a per discharge and the other a per diem, depending on the classification of the patient.

Now we might not care so much whether it's a SNF or whether it's a rehab hospital, recognize what's happening on the ground, which is the distinctions between these facilities are starting to blur, and maybe that's a good thing, particularly if it avoids the transport issue.

Finally, regarding the transport, under the RUG systems, a SNF would be the entity to pay for the cost of the transport presumably and in what's coming down for rehab hospitals they would pay the cost of the transport. At least in the areas that I'm familiar with, in upstate New York or rural Pennsylvania, the only option for this kind of transport is the ambulance company that charges a lot more for a trip than the facility gets paid on a per diem which makes the likelihood of transport a lot lower and adds to the problem if it's a necessity.

DR. WILENSKY: I don't know whether there's anything you can provide us, in terms of an insight to this question, whether if you tried to do the cut on the patient characteristic and then see if you got any better fit using RUGs or FIM-FRG, is really interesting. I don't know whether you can see whether anybody has done that or looked to see whether on a very small basis we could see whether that made a difference.

DR. CURRERI: I have two points. The first is I appreciate your power analysis and I think if we're going to make that recommendation that needs to be included in the chapter as justification for that recommendation. Otherwise, it sounds like we just pulled that off the top of our head.

There is one part of the chapter, however, that I am unclear about and I think needs to have some additional information. That is that I assume that most of these -- and I may be wrong about this -- but I assume that most of these rehab hospitals also have outpatient programs, so they don't always necessarily transfer to SNFs or transfer to home, but that there's a continuing outpatient.

As a TEFRA hospital, I think we have to -- how are those services going to be paid for? Are they going to be paid for like hospital outpatient departments? Or are they going to be paid for under another system?

I think this is particularly important if you're going to have a discharge based payment system because then you have to say what after discharge? Do you have any information about that and do you think we need to add something about outpatient treatment following the discharge, particularly

whether or not we use per diem or we use discharge based payment we still have to account for it? I don't know the answer to those questions.

MS. MAXWELL: First, I do have some information and I'll share it. And also, I do agree. I think that's a good point about within that discussion pointing out basically what the different options are following discharge and generally what the payment systems might be for that.

As far as how outpatient rehab is paid for, it is not a part of the outpatient hospital PPS, which one might think it could have been. With the BBA outpatient rehab, which is defined as basically outpatient rehab that is not in a home health benefit or within a SNF or other actually more inpatient service.

Outpatient rehab is paid for using the fee schedule, using the Medicare physician fee schedule. the reason they're doing that is because independent therapists have been on the fee schedule when physicians went on in the early '90s. If you look at the data and if you talk with the therapists' industries, it seems like there was a shift in certification from being just a regular independent therapist to being a rehab agency. It's a logical move. It took you from the fee schedule with a per bene cap to a cost-based payment without a cap.

Under the BBA, they're trying to make the payment rules the same for those services and don't feel that there's necessarily a huge difference across independent therapists and the rehab agencies. Because of that, they're putting them on the schedule and those outpatient rehab providers, which are mainly hospitals and rehab agencies, and also there's a small number of more comprehensive free-standing facilities that are called CORFs. Those are all moved onto the fee schedule and are coming under this larger payment cap for outpatient rehab.

Originally the cap was to be implemented and it was going to be on a per bene level. Due to problems in basically systems administration at HCFA it's not going to actually be implemented on a per patient level. It was a feature of the BBA that the industry really didn't like, but given the system problems, it's an impact that will be delayed.

DR. CURRERI: I was just wondering if it doesn't make sense, if we're looking for consistency, why would we treat rehab hospital outpatient clinics different than hospital outpatient clinics?

MS. MAXWELL: They're not

DR. CURRERI: They're not?

MS. MAXWELL: No. Before the BBA, rehab hospital outpatients and --

DR. CURRERI: I'm talking about after the BBA.

DR. WILENSKY: He's thinking about outpatient, all the discussion we had yesterday about outpatient.

MS. MAXWELL: With outpatient PPS.

DR. LAVE: I forget the details but there were some caps placed on outpatient physical therapy in some settings and not in others. If my memory serves me correctly, there was no setting limit if they were provided through a hospital outpatient department, but in other agencies they were. For that purpose, is a rehab hospital another agency or a hospital outpatient department?

MS. MAXWELL: Thank you for bringing that up. I should not have left that out. The hospitals are exempt from the cap and that would apply to rehab hospitals also.

DR. NEWHOUSE: Stephanie, do you have some sense of how many rehab units there are versus how many free-standing hospitals?

MS. MAXWELL: Yes, there are 900 units and 200 hospitals.

DR. NEWHOUSE: That's what I thought. Am I right in thinking that when the FIM-FRGs developed the industry was mostly the free-standing hospitals?

MS. MAXWELL: The growth has generally been in the units.

DR. NEWHOUSE: How many hospitals of, say over 300 beds or so, some moderate size, have both a rehab unit and a SNF? Do you have any idea?

MS. MAXWELL: That's a good question. I don't know the answer to that, but I think I could get it.

DR. NEWHOUSE: In terms of where you send somebody, if it's a matter of which floor of the hospital do you send him to, it seems pretty easy to pay the game of maximizing the reimbursement.

What got me to raise my hand though, and this will come up again under home health, was Janet's comment about the case managers. We don't have to answer this now, but I looked at last year's recommendation in the home health area of an independent case manager. And then I began to wonder, to whom this case manager report? What are the incentives of the case manager?

It's one thing in the managed care setting, that I understand. But if we're going to recommend the case manager, I need a clearer sense, at least, of how this is actually going to work. As I say, I was going to raise that again in the home health area. And I don't know, but I think we have to take that step if we're going to recommend it.

DR. ROWE: I think I preferred the per discharge approach. I think that there is this concern -- we have in our hospitals this crazy system where we get per discharge for the patient, and then when we transfer them to the rehab unit it's per diem. There are obviously some advantages --

DR. NEWHOUSE: No, per case. In SNF it's per diem.

DR. WILENSKY: But for the rehab it's per case.

DR. ROWE: Well, we can discuss how individual units are paid, but I think the issue is that if you are paying per case -- one of my major problems in rehabilitation for geriatric patients has always been they don't get rehab on Saturday and Sunday. This whole conversation assumes that every day is equal to the day before and the day after. That's not what happens. You get rehab from Monday to Friday, you slide back on Saturday and Sunday to somewhere like where you were on Wednesday. Then you start your rehab again. And there's this ratchet phenomenon. Rehab is a progressive functional improvement. And if you get it every day it's better than if you don't get it on the weekend.

I know that may seem naive and obvious but it didn't seem like the discussion was necessarily informed by that and it should be, that if you do have a per case system there is, I think -- and if you're going to punish people for "prematurely discharging" people to other facilities because they're not there functionally yet, there would be an incentive to build in as much rehabilitation in as coherent a fashion as possible.

The other thing is there's also an assumption in the discussion that there's not enough demand to fill the capacity. My experience is, at least in some areas of the country, or many -- the area that I work in -- that there's much more demand than there is capacity in rehab. So the real decisionmaking apparatus for the providers is to decide which patients of all the ones who want to get into the rehab beds can benefit the most. And there's not much interest in keeping patients around who aren't really benefitting from the additional rehab because the staff want to know that there are patients out there -- and if you also own the hospital, that patient is sitting in a hospital bed and a DRG waiting.

Our patients apply to get into our rehab facility and they sit around in our hospital waiting to get in. You should be aware that, at least in some parts of the marketplace, that's the case. This not a thing where there's empty rehab beds and people just hop into them.

DR. LEWERS: Jack, I think things are changing. Several of the rehab units that I know now do basically work seven days a week. They have been forced into that. The Saturday-Sunday holiday is gone. Usually Sunday is a fairly light day, but Saturday is a full day in many of these units.

DR. ROWE: That's good.

DR. MYERS: I was going to basically ask the question and make the same point, that we ought to be encouraging the seven day a week approach, as opposed to adjusting the payment system that doesn't accommodate the seven day a week approach. It's very clear, as Jack has already pointed out, that seven days is better than five for a lot of the rehab patients.

DR. NEWHOUSE: It's not clear how the payment system --

DR. WILENSKY: If you have a per diem, you push it harder on per case.

DR. ROWE: If you're paying per diem you're paying for Saturday or Sunday, whether the services are provided or not. So it stretches out to more days. There's no incentive to provide more intensive service.

DR. WILENSKY: This has extended the discussion a long way, but it seemed like it has been a while since we have had this kind of discussion.

DR. KEMPER: I just would like to raise again this issue of comparing the FIM-FRGs to the MDS-PACs. I mean, the recommendation, the way it's stated, doesn't really call for any comparison of the alternative systems. When I think about where we were in the risk adjustment, we had two competing approaches and we really had evidence on both sides of which one was the better at predicting and what the data problems were, and so on.

In this case, we have one system that's very well developed and well documented, and another one where the study, I guess, is still i progress; is that right? And so it's very hard to make a comparison and come up with a recommendation.

I think that really should be a top priority. When does this need to go into effect?

MS. MAXWELL: The staff time study would be done--

DR. KEMPER: I meant the actual payment.

MS. MAXWELL: October of 2000.

DR. KEMPER: So it's not that far away, to be able to look at this kind of comparison.

DR. WILENSKY: You can come back to us next time. Let me try to sum up, I guess, what I've heard. I think this issue, there are a lot of points that have been raised.

It sounded like there was more leaning toward the per case as a payment but some interesting issues that were raised, which is if you have the unit in the floor of a hospital, then having per case which you're already having per discharge in terms of the DRG, particularly when moving somebody from one floor to another floor is less disruptive and therefore may be less of a deal, might be different from if you were having the free-standing facility.

But there was an additional issue that I forgot who raised it, maybe Bill MacBain, about if you looked at patients with particular conditions, did you have an easier ability going between rehab hospitals and SNFs who are certain types of patients? Did some of the problem of going between FIM-FRG and the RUG happen because we looked at too many patients with too many varying disease states? And that if we were looking at limited numbers that were really in different facilities, might we in fact be able to have more commonality?

I don't know whether you'll be able to do that or that's something we'll just have to put on the menu for further research, but at least that strikes me as being an interesting difference that I haven't heard research on, although it may well be that it has been.

MR. MacBAIN: Just one other thought, too, and that's on this notion of a hospital that's got three levels of care on three different floors and seeks to maximize their margin by moving the patients. That may produce a good result and I wouldn't automatically write that off. It may actually cost Medicare less and/or produce better care for the patients. So I think it's worth looking at but that may be exactly what we want to encourage.

DR. KEMPER: Are you eligible for a SNF after a rehab discharge?

MS. MAXWELL: I think so. Yes.

DR. ROWE: What if you came from a SNF? You're in a SNF and then you have a fractured hip, which many patients in SNFs do, and you go to rehab --

DR. KEMPER: It's just a question of who pays, whether it's Medicare or Medicaid.

DR. WILENSKY: Thank you. Dana?

MS. KELLEY: As you know, the BBA mandated the implementation of a prospective payment system for skilled nursing facilities. The transition to the PPS began in July.

The March report will present an opportunity to make formal recommendations regarding some of the policies and procedures governing the new PPS. So today I have some draft recommendations for you to consider. Before I turn to them, let me review some of the basics of the PPS.

Under this system a per diem payment is made to cover the routine, ancillary and capital costs incurred in treating a SNF patient. Patients are adjusted for differences in case mix and area wages. The case mix classification system that's being used is the resource utilization group system version three, or RUG-III.

The RUG system first divides patients into seven categories representing groups of patients with certain clinical characteristics. Within each category, patients are classified into 44 RUGS based on their functional status as measured by limitations in activities of daily living and the number and types of services used.

The next overhead displays the seven RUG categories. Each category is broken down into RUG groups so there are 14 rehabilitation RUGs, three extensive services RUGs, et cetera.

Each RUG has a nursing index or weight indicating the average level of resources needed to provide nursing services to patients in the group. The rehab RUGs also have therapy indexes.

The RUG system can be used for both Medicare and Medicaid payment. Generally speaking, patients falling into the top four categories, that is the top 26 RUGs, would meet the Medicare coverage criteria for special rehab and skilled nursing care. The remaining RUGs are more often used to describe Medicaid patients.

Patients are assigned to a RUG group based on the results of required periodic assessments, which are recorded in the minimum data set or MDS. This is a patient assessment instrument used to develop plans of care for nursing home patients admitted under Medicare and Medicaid.

After each assessment, the RUG group is recorded on the claim and sent to the fiscal intermediary for payment. Assessments are required on days five, 14, 30, 60 and 90. So the RUG to which a patient is assigned can change during the patient's stay.

Once a patient has been classified, the payment for that assessment period is determined by multiplying the applicable RUG weights by the federal per diem payment rates. The final payment then differs depending on the location of the SNF.

The federal per diem rates are the same for both hospital based and free-standing facilities. The rates were calculated based on each facility's allowable per diem cost for reporting periods beginning in fiscal year 1995, plus an estimate of the amounts paid for ancillary services under part B. These costs were trended forward to 1998 and adjusted for differences in wage rates across areas and for variations in case mix across facilities.

Two averages were then calculated, the average per diem cost for all facilities weighted by the number of days of care provided; and the average per diem cost for free-standing facilities only, again weighted by the number of days of care. The final federal per diem rate for all facilities is the average of these two averages. Free-standing SNFs costs, which we know to be lower on average, are thus weighted much more heavily than those of hospital based SNFs.

This overhead shows the federal per diem payment rates. There are four components of payment. As I said, each RUG has a nursing case mix weight to which the nursing case mix per diem payment is applied, $109 for SNFs in urban areas and $104.88 for SNFs in rural areas.

There's also an added non-case mix component for each RUG to cover the average fixed costs of general services associated with the care of nursing home patients regardless of their clinical characteristics or functional limitations. The base payment for this component is $55.88 for urban facilities and $56.95 for rural facilities.

The rehab RUGs also have a therapy case mix weight to which the therapy case mix base payment is applied, shown here in the third column.

Finally, non-rehab RUGs also have an added therapy non-case mix component payment to cover the average costs of the low level rehab services that are provided to patients not in the rehab RUGs.

Now turning to the recommendations, this overhead shows summaries of five draft recommendations for your consideration. I'm going to discuss the development of a new wage index for skilled nursing facilities, the correction of potential distortions in the federal rates, the refinement of the RUG-III classification system, issues related to the updating of the RUG-III rates, and the need for monitoring of SNF reporting and quality of care.

The first recommendation relates to the wage index currently being used in the SNF PPS. HCFA needed a wage index to remove the effects of differences in local wage levels when it developed the federal base payment rates. The wage adjustment was intended to yield an estimate of what each facility's per diem costs would have been if it operated in a labor market with national average wage levels.

Of course, a wage index is also needed to adjust the labor related component of those base rates when making payments to each facility, so as to recognize higher wages in some areas and lower wages in others. Ideally of course, the wage index used in the SNF PPS would be one that was developed using data on the wages that SNFs pay. However, the wage index currently being used is based on wage data reported by hospitals because a SNF wage index is not available.

The Social Security Act Amendments of 1994 required HCFA to begin collecting the data needed to construct the SNF wage index, but this process has not yet been completed.

Evidence suggests that geographic differences in labor prices for nursing facility employees do differ from those for hospital employees. Using limited data one of our predecessor commissions simulated a nursing facility wage index and found it differed significantly from a hospital wage index.

For example, the hospital wage index was much lower than the estimated nursing facility wage index in urban areas of New England and the mid-Atlantic regions, while the nursing facility wage index was lower in the Pacific region.

One reason why the indexes may be different is because of wide variations in state regulations affecting nursing facilities. States, as you know, have a major effect on the costs and staffing of nursing facilities through their certification and oversight roles.

Another reason might be the different skill mixes employed by hospitals and nursing facilities. Nursing facilities employ proportionately more aides and in addition the relative level of aides' salaries compared with nurses' salaries may not be the same across geographic areas. The hospital wage index does not capture these differences.

So using the hospital wage index for a SNF payment may contribute to inequitable Medicare payments across regions. An accurate wage index is needed to properly account for geographic differences in wages. If the quality of the data SNFs submit on their annual cost reports is adequate, then a SNF wage index might be introduced for fiscal year 2000. If not, it will be important for HCFA to focus on resolving the reporting problems as quickly as possible to eliminate this source of inaccuracy in the payment rates.

Of course, a change in the wage index used would probably have redistributive effects and so it may be prudent that such a change be phased in.

Do you want to stop and talk about these now, or should I go through? Okay.

The next recommendation addresses potential distortions in the federal base payment rates. As you know, the costs on which these rates are based were standardized using the hospital wage index. We just covered the reasons why this would not be appropriate. But the federal base payment rates were also adjusted to remove the effects of variation in the mix of patients cared for by SNFs.

The case mix adjustment was an attempt to estimate what each SNFs per diem costs would have been if it served the national average patient mix. Ideally, data from the minimum data set would have been used to classify all SNF patients into RUG-III groups so that an average case mix index could be calculated for each facility. The wage adjusted per diem cost data for each SNF then could have been divided by its case mix index to remove the effects of case mix differences across facilities.

Unfortunately, the MDS data were not available for the base year except for facilities involved in the RUG demonstration. To adjust for variations in case mix, HCFA developed a rough case mix measure based on the limited diagnosis information and therapy charges available on the SNF's claims data.

The information is particularly limited for rehab RUGs since SNF claims do not record the minutes of therapy received, an element that's crucial to classifying rehab patients properly. In fact, when HCFA compared the case mix values generated from the claims with those from actual MDS assessments for a sample of SNFs, they found that the therapy case mix values based on the MDS data were 28 percent higher.

HCFA corrected for these systemic differences but the case mix index applied to any given SNF may be far from accurate.

Reasonable alternatives to the use of the hospital wage index and the SNF claims data for the wage and case mix adjustments were not readily available but some unknown amount of error was certainly introduced into the federal payment rates as a result of their use. The rates may be relatively higher or lower than Congress intended and may be somewhat distorted between urban and rural areas. The accuracy of the rates could be improved as better data become available.

The next recommendation concerns refinements to the RUG classification system. The RUG system was developed to base on nursing, and physical, occupational and speech therapy time. But patients also vary systematically in their use of other ancillary services and supplies, such as respiratory therapy, lab tests, imaging services, and drugs and biologicals.

Because of this, HCFA's demonstration testing the RUG-based PPS did not include the so-called non-therapy ancillaries in the prospective payments. Instead, these ancillaries were passed through and reimbursed on a cost basis.

But the SNF PPS pays for non-therapy ancillaries prospectively by assuming that the use of non-therapy ancillary services is correlated with skilled nursing time. This assumption is highly questionable. Payments therefore may not be adequate for patients who need relatively high levels of costly non-therapy ancillaries, and this could result in access problems for certain types of patients.

HCFA is taking steps to assess the extent of this problem and to ameliorate it. An independent contractor has been hired to evaluate potential refinements to the classification system that could ensure adequate payment.

The next recommendation addresses the RUG weights. Over time, the weights should change as practice patterns, technology, and payment incentives affect the resources used to furnish skilled nursing and therapy services. If the weights are not updated periodically, inappropriate financial incentives may develop as well as payment inequities among providers.

The initial case mix weights were based on staff time measure studies for a relatively small number of patients in a limited set of SNFs. Options for updating the weights include repeating the staff time measure studies periodically for a larger and broader sample of Medicare SNF patients or recalibrating

the case mix rates based on the average charges per day in each RUG group. There are problems, however, with both of these approaches.

Relying on staff time measure studies to update the case mix rates would be relatively expensive because even small staff time measure studies cost several million to conduct. More importantly, though, the rates based on staff time measure studies may reflect what is known as the Hawthorne effect. The staff providing services in the study know that they're being studied and therefore may perform differently than staff in a typical SNF.

In addition, patients in the study settings may be assessed and classified in the various RUG groups more accurately than those in other SNFs. The resulting weights may, therefore, accurately reflect relative resource cost per patients in each RUG group as they should be classified but they may not reflect cost differences among groups given the way patients actually are classified. Such discrepancies would be greater to the extent that RUG assignments in the real world were manipulated to achieve higher payments.

An alternative approach is similar to that used in the hospital inpatient PPS. In that system, the DRG weights are recalibrated annually based on the average charges per discharge in each DRG. Under this method, the weights automatically adjust over time to reflect the effects of changes in technology and practice patterns on all inpatient costs and to account for shifts in patient mix within each DRG resulting from changes in admission practices or coding behavior.

For example, if relatively low cost cases that previously would have been classified in the low weight DRG are coded so that they fall into a higher rate DRG, then the weight for the entire DRG category falls because the relative level of average charges in that category declines.

Whether and how SNF claims data could be used for recalibration would depend on how closely reported charges corresponded to the PPS payment components. For example, because the RUG assignment can change during the patient's stay, charges for each type of service provided would need to be recorded separately for each period during which a patient was classified in a particular RUG.

In addition, charges for skilled nursing care, the costs of which vary across patients, would have to be separated from charges for fixed routine services of the claims are to be used to recalibrate the skilled nursing weights.

Finally, the last recommendation concerns HCFA's monitoring role under PPS. Under PPS, facilities will face strong financial incentives to shift Medicare patients into higher weighted RUGs, so as to maximize reimbursement. A resident assessment, which provides the information needed to develop or modify a care plan and assign the patient to a RUG group includes a number of subjective elements, such as patient performance on activities of daily living.

The RUG assignments also rely on judgments that are largely under the control of the SNF, such as whether a patient needs 480 or 500 minutes of therapy per week. Since the potential for manipulating RUG assignments to increase payments is substantial, it will be necessary for HCFA to develop methods to assure that SNFs accurately assess and report patient needs.

Prospective payment also creates incentives for providers to reduce their costs. This, of course, has implications for quality. It would be important, therefore, to monitor the provision of services to ensure the beneficiaries are receiving appropriate care.

For example, a tracking system might be developed to detect access problems as they arise. Such a system might monitor trends in the mix of beneficiaries admitted for care based on their initial RUG assessments and their use of other ancillary services. But clearly this is an area that will need a fair amount of attention.

It would be helpful to the staff if we could answer your questions about the recommendations and get your viewpoints on them.

DR. WILENSKY: We can either do this by going back to your overheads while you go through each of them, or we can look on the page prior to page one.

MS. KELLEY: The page prior to page one has the details.

DR. WILENSKY: That has the summary of each of the recommendations.

First, let me ask whether people have any general comments on what you just heard and then we can go through the recommendations and talk about them. We can come back, you don't need to feel like you're making final recommendations today. We will come back early in the meeting in January and discuss all of the issues of this afternoon.

MR. MacBAIN: A couple of things. One is just a question for clarification, and that is in calculating the federal per diem, where do the swing beds costs show up? The cost for the swing beds, are those treated as hospital beds?

MS. KELLEY: No, the swing beds, the Secretary was given the authority to pay swing beds on a different method during the transition period. To be perfectly honest, I would have to let someone from HCFA address how they were going to deal with that during the transition. But I believe after the transition period they'll be paid on the prospective payment.

MR. MacBAIN: I think they weren't going to do anything for the first year but I wasn't sure whether the cost of the swing beds were part of the data base used to calculate the federal per diem.

MS. KELLEY: I believe that they are.

MR. MacBAIN: And they're treated as if they were hospital based?

MS. KELLEY: I believe so, yes.

MR. MacBAIN: That accentuates my comment, and that is for a lot of rural hospitals the revenues from hospital-based SNFs and swing beds are a crucial part of their overall financial performance. I really think it would be appropriate to consider a recommendation specifically focused on evaluating the impact of these changes on rural hospitals because we are both moving from payment based on the costs of hospital based units to something halfway between there and the free-standing units, which means that part of the hospital's overall cost of operation that was allocated that used to be recovered now won't be recovered. For a lot of facilities there's no place else to recover that.

At the same time, we're now adding in the cost of the ancillaries. Particularly, the point I made earlier, the cost of something like an ambulance trip to take a patient to the city hospital could wipe out several days per diem income and is either going to do some serious harm to the hospital or is going to create access problems because they simply won't be able to admit patients who are likely to need transport into the SNF to begin with.

DR. LAVE: I have a question and basically two observations. The question is why is the rural therapy case mix $13 higher than the urban one? That strikes me as being quite large and I didn't understand how it got there.

MS. KELLEY: I can't speak to the magnitude of the difference but those are the rates after they've been adjusted for differences in wages. So when the rural costs were accumulated they would have been divided through by the hospital wage index which, for those facilities would have been -- for many of them would have been less than one, inflating the base payment rates.

When they go back out as payments, of course they'll be adjusted again, the labor related portion will be adjusted again by the wage index, making the payments lower.

DR. LAVE: The other question and another sort of partial recommendation, the question on correcting the distortion on the base payment rates, I hope that we only want to have to worry about when we get some RUG data to do that, not to try to improve the fake way that we did before. That has an observation with respect to the appropriate timing of that recommendation.

The second issue is one of the questions and concerns that I've had about the SNF PPS and the way it was constructed is the fact that for a lot of the Part B services, they were really not in the

base. I really am very curious about sort of once they are required to put them together, how well did they capture them to begin with?

I really think that maybe there ought to be a recommendation that looks at that because we really were pulling in a lot of services, like the ancillary services that Bill has been talking about, some of the Part B services that previously were not billed through the SNFs, in terms of setting the payment rates. They could have been way under or they could have been way over. I don't want to judge where they were but it does seem to me that the basis of the collection of the data for the SNFs was quite different from that which was available for the hospitals.

I think that we may want to look at that or have a way of looking at it in looking at the assessment of -- if the payments are an awful lot less than the costs, has it really got to do with the fact that we got the initial payments really wrong because we didn't capture all that information appropriately.

DR. WILENSKY: Let me ask you, Judy, would you see that as an additional statement on the third recommendation, in terms of defining the RUG classification or would you just put that?

DR. LAVE: It really isn't a RUG classification system. It has to do --

DR. WILENSKY: It really has to do with the data that is used.

DR. LAVE: It really has to do with the base payment rate but not a base payment rate that has to do with misclassifying the case mix index. It has to do with misclassifying the original costs.

DR. WILENSKY: Okay.

MS. KELLEY: One thing, ProPAC did a study looking at how the extent to which facilities were billing outside of Part A for their patients. We were able to look at a sample of patients only but we found, and HCFA has had similar findings when they've looked at it, there's actually a very small proportion of total payments come through Part B ancillaries. I think we found something like 2 percent of total payments.

DR. LAVE: All I know is that most of the hospitals in Pennsylvania they didn't do the billing. It may not be a problem.

MS. KELLEY: But it's something to be looked into, sure.

DR. WILENSKY: I think one of the things we can do is to look at the recommendations as they are, covering the correction of the distortion, the wage index refining, look at those first three and then maybe the last two and see if in principle these are issues in which people are comfortable that we would make a recommendation.

It seemed fairly straightforward areas.

Also on the last two, in terms of updating the case mix weights and also reporting the monitoring of the services reporting. Is there anybody that is uncomfortable? This is not a final sign off but these seem like five very straightforward kinds of recommendations.

MR. MacBAIN: Just a thought on the last one on services furnished, and that's the impact of paying for drugs through the RUG and whether that's going to have an impact. What I was thinking about mostly is what's the effect on pain medications where it's difficult to measure whether it's adequate therapy or not.

Again for a lot of institutions, particularly smaller ones, this could be a substantial hit.

DR. NEWHOUSE: I had the same thought, only more grandly. I was going to propose to add a sentence to that last recommendation that said this is particularly the case with respect to services that are not explicitly accounted for by the RUGs classification system, as a way of trying to focus the monitoring.

DR. KEMPER: I know in our discussion of quality, HCFA had some activities related to SNF quality assurance. I recognize this is mostly about payment. I wonder if those could be discussed in the context of this last recommendation?

MS. KELLEY: Certainly.

DR. KEMPER: Maybe there's something that could come into the recommendation from that.

MS. KELLEY: Okay.

DR. WILENSKY: People should look, if they can, either go back to look at what they have or when they get the material for next time, to look to see whether there are any additional areas in which we would be comfortable making recommendations. And Dana also, if there are other issues that you think we need to take up.

MS. KELLEY: Okay.

DR. WILENSKY: Thank you. Louisa?

Louisa, in your presentation, I don't know when we may start losing Commissioners, but if we can do a crisp presentation so we can get some response, it would be good.

MS. BUATTI: In response to one request that I received from a Commissioner, before I talk about the recommendations I just want to quickly update the commission on the PPS development efforts, since I haven't given a presentation on this topic. Just to answer anyone's questions about why there are no recommendations in the chapter on this area, the system is still in the early stages of development and more information will be available shortly. The commission will have several other opportunities to address any concerns they might have. But I thought I should let you know what's going on right now.

DR. WILENSKY: Do you anticipate that for our next meeting? That kind of shortly? Or after that?

MS. BUATTI: There may be a little more information available by the next meeting. As you recall, the Secretary is required to submit a report to Congress outlining her research activities and an implementation schedule for PPS. That is due January 1st. It's possible that that information will be available by the January meeting.

DR. ROWE: Has that schedule shifted or changed?

MS. BUATTI: The schedule has shifted based on the budget provisions that delayed the implementation of PPS by one year to October 2000.

DR. ROWE: The Secretary is still planning on making that report at the time it was initially --

MS. BUATTI: Yes, that was one of the requirements that was put into the budget.

HCFA is currently conducting a demonstration project where home health agencies are paid a fixed amount for a bundle of services provided during a 120-day episode of care. Under the demonstration, episode is defined by gaps in service of at least 45 days. Only after the 120-day at risk period, and at least a 45 day gap in services, would an agency receive additional per episode payments.

Under the demonstration, episodes that last longer than 120 days, the additional visits that occurred after 120 days were paid on a per visit basis.

Under a separate demonstration HCFA is developing a patient classification system. The system is based on the outcomes and assessment information set. This was originally designed to measure outcomes for quality assurance. OASIS represents core items of a comprehensive patient assessment tool encompassing sociodemographic, environmental support, health status and functional status items.

Additional clinical indicators have been added to strengthen this instrument's ability to predict resource utilization. Ideally, the final instrument that is used by HCFA will be able to predict resource use of diverse patient groups as well as measure outcomes for quality assurance purposes.

As I mentioned at the beginning of the presentation, the commission will have several opportunities to comment as more information becomes available. In addition to responding to the January 1st report to Congress, the commission will have the opportunity to respond to the proposed rule

on the prospective payment system. In addition, we will be able to make recommendations in the March 2000 report.

So now I want to turn to potential recommendations for this year's March report. Three of these, standardized coding, case managers, and copayments were recommended last year.

Little is currently known about the content of the home health visit. As you may recall, home health agencies report the type of visit that they provide. In addition, home health agencies are now required to report the duration of home health visits. However, the content of the visit, the services that are actually provided, is still not reported.

Standardized coding is important for a few reasons. First of all, it would allow for a comparison of services provided across home health agencies, as well as a comparison of utilization of home health services over time. Even under a PPS that would use a bundle of services as its payment unit, encounter information is important to monitor the quality of care.

In addition, more information about services that are actually provided under the home health benefit would also help to better define the scope of the benefit.

Home health was originally designed as a short term benefit for patients needing skilled care following a hospital stay. Current Medicare eligibility guidelines require that beneficiaries be homebound and need intermittent skilled care. Once eligible, they may receive any number of the qualifying services plus medical social services, occupational therapy, or home health aide services.

As you'll recall from our previous reports, the growth in home health utilization has been fueled by both an increase in the number of beneficiaries receiving home health services as well as an increase in the number of visits they received. Recent efforts to control utilization have focused on payment policy changes, but because there are many challenges associated with setting payment rates for a diverse group of patients, additional approaches should be considered.

The Secretary is preparing a report on the definition of homebound and is also working on developing normative standards for home health care. One possible recommendation is that the Congress should go a step further by reconsidering the overall scope of the benefit in terms of who should receive home health services, as well as clarifying the services provided under the benefit.

In addition, the Secretary could be given greater authority in the law to enforce such guidelines.

Another non-payment tool for controlling utilization is a case manager. Case managers would review the plan of care for Medicare beneficiaries who receive home health services for extended periods of time to ensure that these services are meeting the patient's needs. The case manager would then make recommendations to the certifying physician about changing the plan of care as needed.

Requiring a case manager would help to improve outcomes for certain types of patients as well as ensuring the appropriate level of care is being furnished. To address the issue that Joe brought up earlier about who the manager would report to, one option would be for a separate payment to be made to the manager, separate from the agency payment and separate from the physician payment. That way the manager would really be working for the beneficiary.

The fourth recommendation, as I'll remind you, was made last year by the commission and one of the predecessor commissions, and that has to do with home health copayments. Home health and clinical lab services are the only major Medicare benefits for which there's no beneficiary cost sharing. Copayments could serve an important function by highlighting the costs of providing home health and allow closer scrutiny of services being billed.

This could help to identify fraudulent and abusive practices. In addition, the need for continuing care could be evaluated more critically than currently.

Under a PPS that uses an episode of payment, cost sharing could be imposed in a number of ways. One option would be a copayment based on a percentage of the Medicare payment for

the episode. A second option would be an episode based deductible, another deductible covering a different period of time.

This final possible recommendation is a companion to the recommendation in the PPS-exempt chapter that Stephanie presented. It concerns collecting common data elements where appropriate across post-acute settings to facilitate the comparison of patient needs and resource use in these different areas. This would help to identify the nature and extent of overlap in post-acute services. In the long run this could be used to form future payment policies.

The commission could decide to include this in the recommendation format or just in the body of the paper. Or if you like, you could wait until more information about HCFA's instrument is actually available.

DR. WILENSKY: Let me open this for questions in terms of the material that's been presented and then we can have a discussion about some of the recommendations.

DR. CURRERI: I think, if I'm not mistaken, nobody is eligible for home health care without a physician requesting it by some sort of prescription?

MS. BUATTI: Right.

DR. CURRERI: I really want to comment on Joe's point. I really think the case manager is a very valuable asset because many of these patients are located at some distance from the physician, are seen only periodically or not at all frequently for their chronic illnesses, or are homebound and therefore rarely seen by a physician.

So to have somebody evaluating in the home and then report independent of the home health care agency and report back to the physician, to my mind would ensure better utilization of home health care services.

I think, though, that that part of it; that is, in your recommendation -- I agree with your recommendation but I think you should add into the recommendation that that person reports back to the prescribing physician. It's in your text, but I just think it belongs in the recommendation, too. Otherwise it sounds like this independent case manager is going to operate entirely by themselves.

MS. ROSENBLATT: One comment on case managers and one on copayments. On case managers, Joe I'm waiting to hear what you're going to say because I have a similar concern. But if we could figure out who the case manager works for and set up something, it seems to me that it might be able, that a case manager could help on all three of the things we've been discussing this afternoon on the rehab and the skilled nursing and on home health care.

I don't have any brilliant ideas but if there is one out there it might be very helpful.

On copayments, I'm undecided where I was. I think last year I was kind of not too hot on copayments and I continue to be not too hot on copayments. And one of my concerns in reading the paper is that there's an implication that anyone who's got a Medigap policy will be okay and that the only beneficiaries affected by this copayment are going to be those without Medigap. And I just want to make sure that I think your language needs to change a little bit, that the Medigap population will also be impacted by if you add a new benefit you've got higher premiums.

DR. ROWE: The chapter says that Medicare would actually have to be changed in order to permit the Medigap--

MS. ROSENBLATT: I know, but I'm just saying that it sounded like the financial impact would hit just those without Medigap and what I'm saying is there is a financial impact for those who have Medigap because if you add more benefit the premium will go up. That's my only point there.

DR. NEWHOUSE: Before I get to case manager, on the information on the content of the visit on the bill, I guess my concern is for either duration or content, to what degree is that auditable? I mean, somebody writes down something on the claim but how do I know that corresponds to reality? That's actually a question.

We require now presumably information on duration. Is there any effort to audit that information? If so, what is it? How would you do it?

Some agencies require the employee, when they get to the home, to punch in a phone number when they get there and then punch in a number when they leave so you can verify the time that was spent. I can understand how that could be audited. But for those agencies that don't have that capability, I don't know what one does about whether this is information that has any validity or not. And I don't know what we would do about the content of the visit.

Have you thought about auditing that?

MS. BUATTI: Actually, I haven't thought too much about that.

DR. NEWHOUSE: I think we need to think a little about that or we're just going to collect information and we won't know what we've got.

On the case manager, I just again think we need to think harder, but I've got a bunch of questions that I thought of about this. One was the one I mentioned, to whom does this person report? Or are they just self-employed? What's the person's incentives? Do they get a fee? How does the fee change with the length of the case? I mean, presumably it takes more time to manage a case that's going on for several months. Who invokes this case manager? Does every patient -- we presumably don't want the patient that's going to get three visits --

DR. WILENSKY: I thought we had it after 60 days.

MS. BUATTI: I don't know that we actually specified last year. We had a lot of discussions on this topic about length.

DR. NEWHOUSE: We need to have some discussion of that. And who assigns a specific case manager to a specific patient? What do we envision?

I guess although this seemed like a good idea last year, the more I've thought about it the more I'm puzzled about just how it would work. I think one reason might be nobody paid any attention to it and we didn't say how it would work.

So if we could be more specific about what we think would happen, I think that would be better.

MS. BUATTI: I'll think about it and present you with some options next month.

MS. NEWPORT: Basically, to follow along in the same vein, I don't think we want to move fraud and abuse up to a higher level. Independent case manager, that independent word bothers me. I think we need to look at audit trails and -- I have my compliance hat on, I'm afraid.

I think the other part of this goes to what's the optimum number of cases to manage? You could have someone potentially who's indepedent and meets all the other criteria and they've got 10,000 patients. That's not a good staffing ratio, if you will.

So I think that we might want to put some bounds in terms of how to take a look at this.

DR. KEMPER: On the case manager, I guess I think this is an area that requires a lot of precision, maybe that's what you're saying Joe, in terms of the way it works. It seems to me a home health agency already does case management. If they're not managing their cases, I don't think that's good clinical practice.

So in that sense I think adding a case manager could be adding a service to Medicare. And I would think that that service would be manager of a much broader array of services needed by an impaired person beyond just a home health aide or nursing or therapy, but the home delivered meals, the whole set of things that a client might need.

So I guess I would think that, if you thought about adding a case manager, it's important to think about that as adding reimbursement for a service and to evaluate it in that sense, rather than thinking of it as a way of limiting the use of home health services.

I thought the discussion that we had the last time we had this discussion was more for the very long stays --

DR. WILENSKY: Exactly.

DR. KEMPER: -- not to have a case manager, but to have an independent assessment of need.

DR. ROWE: An auditor. We said we had to have a trigger.

DR. KEMPER: That's a very different kind of -- and that's not so hard to think about how that could actually be done.

DR. WILENSKY: Let me recollect the context in which we had this, before we go on to the next two people. It was in the context of wanting to make sure that people who were having substantial numbers of visits had an assessment about their continuing need for additional home care.

We discussed, although it may not have been in the context of the actual recommendation, something like around 60 visits. That after that point we wanted to have somebody who was not an employee of the home care agency come out, make sure because we are aware of pressure being put on physicians to keep authorizing home care because there was no reason not to provide this service since the individual was not paying for it or there was a very modest copay, were the words we used, with a cap that would already have kicked in, to make sure that there was a need for continuing care and something about the kind of care that was needed.

But it was not a case manager in the sense in which we talk about that concept in other areas. I think that what's been raised today is something that, to my recollection, was not at all assigning a super case manager that would be advising the home care agency and/or the patient.

DR. CURRERI: My recollection was that we were specifically trying to address the problem, and I probably have the numbers wrong, that 5 percent or some low percentage of the patients were spending 50 percent of the monies because they were getting over 200 visits per year and that's where we really wanted to focus our attention.

DR. ROWE: The good news here is that we're coming back at the same point that we were a year ago. It would seem to me that we might be able to resurrect the record --

DR. WILENSKY: We can go back. We can go back and provide that, but it was also acknowledging that the physician frequently had an unreasonable burden being placed on him or her or the patient's family.

DR. ROWE: The patient wasn't paying him and there was some benefit.

DR. WILENSKY: And to continue doing this. So to make sure that you had appropriate care and that there was some assessment, both to make sure that people got the care they needed, and that it was continuing on an appropriate basis, that after some extended period we would have someone come in and do an independent assessment. But not case manager in the way that that concept was used elsewhere.

DR. KEMPER: The second comment I had has to do with the recommendation on the eligibility and coverage guidelines. I take it the Department doesn't feel that it has authority to work on eligibility and coverage guidelines?

DR. WILENSKY: It lost a rather significant court case on that issue.

DR. KEMPER: I guess I would focus that recommendation on the eligibility and coverage guidelines rather than reconsidering the whole scope of the home health benefit, just focus on the eligibility and coverage.

I guess the third thing, I guess like Alice, as I look at the copayments recommendation, while I think I in a straw vote agreed to it last year, it's awfully weakly justified here in terms of what the value of it would be.

DR. WILENSKY: I'm not going to ask people at this point to take a stand, this week.

DR. KEMPER: That's fine but I would argue that we just not reiterate that. We can discuss that at the next meeting.

DR. ROWE: Do we know whether it does have any effect, an anti-fraud effect? The argument, as I recall the document, says that it may have an anti-fraud effect because the patient realizes that somebody's billing for services. Then it said in the next sentence there is a form, the patient does get a summary [inaudible].

DR. KEMPER: That was my question. The fraud and abuse was the main justification.

DR. ROWE: Are there any data on that?

DR. WILENSKY: If there's anything to shed light on this case...

MS. BUATTI: I'll look into that

DR. WILENSKY: I wanted to comment on something that you just said with regard to the eligibility. I'm guess I'm not quite sure what we can expect HCFA to do with regard to the guidelines because of the history that has gone on.

If we were so inclined, and I'm not suggesting this as a recommendation, we could make a recommendation to the Congress to be clearer in statute about what it was intending. I could see some value in that, but I'm not sure what having HCFA try to deal with this will do, since it doesn't appear that the statutory language is such that it really is able to do anything with their guideline.

So I would think if we were going to make a recommendation, this would be in the area of a recommendation to Congress to be clearer about what it was intending, if we were so inclined to do that.

DR. KEMPER: It would be nice to know what guidelines people are following now, what really is the de facto eligibility criterion, particularly for these long stay patients.

The last question I had, and I'm sorry I had to step out, but we will know what the proposed payment system is in January, in a month?

MS. BUATTI: I don't know that we'll necessarily know all of the components. We may have some sense of the results of the research they've conducted, but I think it will be longer before we know all the details.

DR. KEMPER: Again, when does this one go into effect?

MS. BUATTI: October 2000.

DR. KEMPER: So we're looking for consistency across payment. There's one consistent item between the rehab and the home health, and that is it's very hard to make a judgment about what's going into effect. So I would just argue that we should urge HCFA, maybe informally, to make public as soon as possible the strategy, and particularly the evidence which is behind the payment mechanism they're planning to use.

DR. LAVE: I had a couple of questions. The OASIS system, does that provide any information on what happened during the visit, or does it only provide information on the characteristics of the patient?

MS. BUATTI: It's my understanding that the actual OASIS just provides the patient characteristics. In the demonstration visit content information is being recorded, however.

DR. LAVE: The second question that I have sort of goes back to the case management issue. What strikes me is that there have been a number of people who have been working on what's called modernizing and updating traditional Medicare. I've been trying to think about how to bring some modern management tools into traditional Medicare, assuming that those two are not mutually exclusive terms.

I wonder whether or not, in fact, this is not one of those issues that we really ought to be thinking about and wondering whether or not the people who have thought about this might help us on how to deal with this problem. I mean, this is a clear problem. To me it strikes me as if there are strong management issues that are involved here. And I wonder if they could be helpful in trying to think about

how to bring more modern oversight into the fee-for-service post-acute care system in a way that might make some sense. I think people might have thought about it.

The thought that occurred to me was that this could be a job that would be delegated to the intermediaries or whoever it is who would have the information that would trigger the time period that would be available. There are people who have that particular information. And that it could be a responsibility that could be delegated to intermediaries, in fact, who are theoretically responsible, at least, for some of the care and observing what is going on.

So that would be at least a locus for thinking, as a first step where you might trigger -- they would know they paid for 60 visits.

DR. WILENSKY: One of the things, I remember PPRC had a report that was done looking at mechanisms the private sector used to get appropriate amount of physician visits and concluded that traditional Medicare typically did not use either three out of four or four out of four that the strategies that the private sector had been using.

In line with Judy's comment, I don't know whether you'll be able to do it for the next meeting, but if you could if there's been some work done to try to get some sense about whether there are strategies that are being used by other groups to try to do that.

DR. LAVE: NASI had a report out on this and I don't know whether or not if you talked to them it would be helpful.

MS. ROSENBLATT: Can I just add tack on to that for a minute? There is an expression managed indemnity. And I think what we're heading towards is the idea of managed indemnity, which I think is a great idea. And if the intermediaries are going to do that, there needs to be extra payment for it.

DR. WILENSKY: Duly noted.

MR. MacBAIN: A couple of comments. One is on the copay. I have traditionally, in a couple of past iterations on this, not liked the idea of copays. I still don't, frankly, but I've learned something I didn't know in past years that modifies my position a little bit, and that has to do with the average length of stay of Medicare SNF stays, which I believe is about 20 days, which not coincidentally -- or maybe coincidentally -- coincides with when the copay kicks in.

So despite the impact of Medicare supplemental and Medicaid, the copay seems to have an impact, whether it's on the patient or on the provider that just doesn't want to bother with having to bill for the copay, something is happening.

DR. KEMPER: That's a whopping copay.

MR. MacBAIN: That's significant. On the issue of fraud, I'm concerned that introducing a small copay, where the cost of collection may be as great as the cost of the copay, we just create another incidence of fraud, that the agencies won't bother to collect it and thereby collect Medicare fraud. And we'd accomplish very little.

If the concern is reducing long episodes of care, reducing the number of home visits to a reasonable amount, then I think we'll get a better result by using the case manager. With a case manager, I think Judy's right. These could be employees or subcontractors of the fiscal intermediaries or of the QYOs or HCFA could directly let a contract in a region. Probably a national contract would be a difficult thing.

I'm trying to imagine how this could spin out. An agency could get a contract for a certain service area, be paid on the basis of the number of beneficiaries living in the service area who are not enrolled in Medicare+Choice plans. While I like Peter's image of what a case manager might do, that probably belongs to the realm of 2004, 2008, out when the whole thing finally gets straightened out, just before we all retire.

But in the interim, I think we have to be realistic and recognize that the case manager is going to respond to whoever it is who pays the case manager and do whatever they're paid to do. And as we're describing it, they're going to be paid to discover days of service that don't need to be provided and prevent them from being provided. So that in putting in a case manager, we also need to be sure that they don't become the utilization police and get overly zealous. So there is a quality concern that has to go along with this.

Which is the say that happens in managed indemnity. It is, I think, a bit more of a concern here because, unlike commercial insurance companies or commercial or Medicare HMOs where the beneficiaries can vote with their feet the next year and go someplace else, in a lot of cases these folks can't or won't. They're in fee-for-service Medicare, they're not going to leave. They'll put up with whatever is done with them.

So I think we need to be concerned that we get the desired effect, which is to reduce or eliminate services that don't provide value to the beneficiary without doing harm to the care being provided and that's always the golden rule. But I think we need that balance. And I think it probably belongs in the recommendation that there needs to be some way of maintaining that balance.

MR. SHEA: On this audit notion that we kicked around last time and again a little bit here, is there any experience with this sort of thing in any long-term care program? Or is this just an idea that we've had that sounds good to us?

MS. BUATTI: I'm not aware of any but I can look further and get back to you.

MR. SHEA: There's experience with case managers.

DR. KEMPER: There's certainly lots of experience in assessment for eligibility determination for state home care programs and for private insurance programs, as well. So there are people who do this and there's a fairly well developed set of tools.

But this is not unrelated to clarifying the eligibility guidelines because they have to have something to assess and judge against in terms of --

MR. SHEA: So there is some state experience?

DR. KEMPER: Yes, I would say quite a bit. Often it's combined with case management, but not always. So you could just have what we were talking about, which is the independent assessment or reassessment of needs.

Now to my knowledge, and others will be more knowledge, sort of a post-acute kind of assessment would be a little bit less usual because that's not what the state programs are. So it's not a big change.

MR. MacBAIN: Gerry, one of the things that we did with Geisinger's in both commercial and Medicare enrollment was have people randomly call beneficiaries who received home health services, just to find out how happy they were with the service, to get an evaluation of the agency and the overall impression of quality of care.

It wasn't a very rigorous audit but it was a sense of follow through. And the agencies were aware that this was happening, which gave them a sense that if they did well it would be noticed and if they did poorly it would be noticed.

MR. SHEA: It sounds like it would be worth taking a look and seeing if there's any useful lessons here, particularly in light of -- Gail reminds of the point that we're trying to find some way to take the pressure off the provider who is often put in the middle on this thing.

On the copay, I thought this description was a very sort of benign, gentle version of copays, but I still am not convinced that you can get there from here copay-wise. You can certainly stop people from using the service if you put the copay high enough, and I think that's probably the experience, with or without the coinsurance, in the SNF situation. On the other hand, if it's small enough why are we bothering with this thing?

Again, even small ones, for people who have major uses, for whom this is the daily visit that keeps them out of the facility, it can be pretty burdensome.

DR. WILENSKY: We will take this up at our next meeting. It was why we had put a ceiling or limit on the aggregate amount. But the question of if we do that and it's small do we really accomplish what we want? Is there a way? I don't know what has happened in terms of the homebound definition, but it is my observation that what some of us would think about the term homebound is obviously not being used. So I don't know what is being used but I'm not sure it is a HCFA guideline issue.

It's why if there was a wish to have somebody go be clearer about what this intended benefit is, I don't think it's a HCFA issue. I think it's a statutory issue because my observation has been that HCFA just finds itself hauled into court and you have judicial review because of what must be an inadequately specified legislation.

I mean, I don't know that to be the case. I just surmise that by what's happened.

DR. KEMPER: Perhaps we can learn more about that.

DR. WILENSKY: Maybe for our next visit.

Any additional comments? We will try to start this whole afternoon's discussion earlier in our January meeting. I think this notion of rotating when we place sections is important. It's not just useful in survey data because you get different answers depending on the order, but in terms of this kind of attention and time we have for these various issues --

MR. SHEA: And we clearly know that the productivity discussion could go last and it would still get some people going.

[Laughter.]

MR. MacBAIN: Can I just make a closing comment before public comment? It doesn't have to do with this specifically, but just my compliments to the staff overall. I may groan about having to read all this stuff, but you folks have to write it.

In two days, you have really helped us focus and walked us through a tremendous amount of information. Coming from a ProPAC background, where we dealt with only about half of this stuff in anticipation of a March report and it took us a good deal longer to get through it.

I really want to, Murray, give you and your staff my compliments. I think you did an outstanding job.[Applause.]

DR. WILENSKY: Let me open this for public comment, but before you start, for anyone in the audience who's planning to come to our January meeting, please note that it will not be here in January. We're going to be at the Crowne Plaza at 14th Street and K. So don't come here in January. Or come here, but don't expect to find us.

MR. KALMAN: My name is Ed Kalman. I am general counsel to the National Association of Long-Term Hospitals and I'd like to briefly address a few issues.

First, with respect to the question of whether you should have consistent payment systems, I understand the issue there is substitution and overlap. Speaking from the perspective of long-term hospitals what I would understand is if we deal with the question of consistent payment systems, then we could have the same payment regardless of the setting.

If you look at long-term hospitals, an entity cannot be a long-term hospital without a 25-day average length of stay. So if you cast that in terms of payment, there is a high weighted payment, whether it's a high weighted RUG or a high weighted DRG.

Since our organization has just completed doing a DRG-type of study, we know what the difference in standardized payment amounts is. For short-term PPS hospitals it is generally $3,900 before adjustments. In long-term hospitals, prior to adjustments, it is generally marginally lower than $20,000 per

discharge. So you don't want entities to get their hands on $20,000 per discharge unless they're doing something different.

If HCFA continues doing what it's doing, it will have a high weighted RUG, which will have a higher payment of the same order than in other settings. So where I thin this will ultimately come down is if there's going to be a high weighted payment because the patients use different resources, and that is why there is a high weighted payment, then there will be different payment systems.

Now you might have the same classification system but I don't know what that is worth, because it will not be a different payment system and you'll have to come to grips with some barrier to get into these institutions. Now currently it's 25-day average length of stay before you can be a long-term hospital. Maybe it will be something else.

But as you think about consistent payment systems and overlap, I wish you could think about that.

Which brings me to the question of overlap. Our research shows that the weights are different on DRGs between long-term hospitals and short-term acute hospitals. And we have 179 DRGs with 25 cases or more over two years. So the patients receive different services and use different resources in long-term hospitals than acute hospitals.

SNFs are not paid to do what long-term hospitals do, so they don't do what long-term hospitals do. SNFs are not paid on a per diem basis, whatever $20,000 comes out to per discharge which we also have it in a per diem, I assume. So we think you should come to grips with those questions.

We have special issues around the unit of payment, per diem versus per discharge. In addition to the discussion here, I would like to add what we all know, is that if you have a per diem payment the incentive is more days. If providers produce more days, then there is a question as to how does that affect the benefit because if the incentive is more days, you keep the patient longer, we're dealing with the outliers of the Medicare program and we're concerned about them exhausting their Part A days and crossing over to Medicaid and to Medigap and to poverty in many cases.

So when you think about per diem, please think about that incentive. Think about the increased coinsurances that it will cause and think about the ability to game between providers that will own both. Exhaust the Part A days on the hospital side and then exhaust the Part A days on the SNF side.

With regard to the question that came up earlier, where are the long-term hospital cases in areas of the country where there are not long-term hospitals? Our best guess, with a little educated guess, is they are extreme outliers in the Medicare program and they don't necessarily get the services that they get in a long-term hospital, as shown by our data. Put in a practical sense, if we're dealing with weaning patients and a case stays in ICU for two or three months, that case has other medical complications, might not get the same team approach with rehab for a sick patient and other things that they get in a long-term care hospital.

In other cases, we believe that they do bounce back and forth between hospitals and SNFs, which is not good for patient morbidity and is not good for payment.

Finally, with the question of palliative care, which one of the commissioners asked, in my experience there is one fine hospital in the United States that delivers palliative care. It's in New York, it's the Calvary Hospital which is primarily a cancer hospital with long stay patients. Most long-term hospitals, between 60 and 70 percent of the cases go home, not to a SNF. And they do go home with home health care.

Which brings me back, as a last matter, to per diem, something I forgot to say. Our take on how to deal with this problem, especially with the longer stay, cases that require a hospital level of care, is that you have a very broad transfer rule. So it doesn't really pay, in a financial way, to discharge before the geometric mean of a DRG. And then you have a larger or higher outlier pool. PPS it's 5 percent. In our system it's 10 percent to protect these patients.

MS. ZAHLER: I'm Carolyn Zahler with the American Medical Rehabilitation Providers Association. I wanted to just comment on four things.

First, was a technical response to an issue that you had raised on the number of minutes per week given to a rehab patient. That was in the highest SNF RUGs it's a minimum of 720 minutes for rehab hospitals. That's three hours per day. So that's three hours times five times a week minimum, sometimes three hours times seven days per week minimum. So that's 900 minutes minimum.

Moving on, we'd like to say that we strongly support the commission adopting a per discharge approach to the payment unit for rehab. We have expressed this in a position paper to the staff. We'd be happy to share it with the entire commission.

We've also heard that HCFA has said in meetings with us that it's overall long term objective is to move the entire payment system in post-acute to a per episode approach but it can't get there now, it needs more data. We think that with more data over time you can probably move SNFs to per diem but then per episode, but don't see making sense of taking rehab from its current per discharge approach back to per diem to come back to per episode.

So we also think that some of the incentives that have been the question of stinting care or not stinting on care, as I heard one commissioner reference, we think those can be addressed in a per discharge payment system and have given some recommendations along those lines.

One thing is per discharge accounts for both intensity of stay as well as duration of stay when you're trying to predict resource use. When you go to per diem, you're only accounting for one of those factors, which is just intensity of stay. So we think you can have a higher predictor of resource use using the per discharge.

And finally, one of our concerns is that on per diem you may have an increase of length of stay. That may be clinically appropriate, it's true. We're concerned that in the long run that may lead to longer stays with some concomitant problems which were addressed by the commissioners, and an increase in payment under Medicare.

Our analyses would show that for each day length of stay under Medicare, the Medicare system would be paying out $235 million more per day. In discussions at HCFA, the response has been well gee, if we see the length of stay go up and the amount of money going out the door going up, maybe we'd have to change and lower the per diem rates, which would then, we think, have a negative impact on the ability to deliver services. So we strongly support the recommendation of per discharge payment unit.

We would also support the recommendation, our other major area of concern is how the staff time measurement study is being approached, both with respect to sample size and methodology, and we've stated this in a series of papers to HCFA which have been shared with the staff, which we'd also be happy to share with the commissioners.

I know you want more paper in your life.

We believe that the sample size should be larger. The current 2,000 cases is one-fifth of 1 percent of the number of patient days in rehab. Or if you take that in number of cases, it's two-thirds of one percent of the number of cases in rehab. So we support the recommendation that it be changed. We've given a recommendation to the staff regarding the size, using a patient classification groups from Rand of a minimum of 50 cases per classification group.

We also don't necessarily see this as a FIM-FRG versus -- emphasis on versus -- RUGs approach to how to predict resource use for patients and assure that all patients get the care that they need. Along those lines, we have given HCFA a recommendation where we have suggested taking the Rand patient classification groups -- and Rand now has FY 1997 data on rehab patients for at least 180,000 Medicare patients from over 600 facilities -- updating those groups, taking those groups then into the field and doing staff time measurement studies in areas where the Rand study may have been weak -- two of those areas are on the nursing costs and probably on some of the ancillary costs -- combining those two

efforts and looking at the weights and looking at the groups and then going forward with the design factors.

I am very much short-handing a series of recommendations that we have made but we would again urge you to take a look at those. And in your recommendation that talks about looking at prior and existing research that has been done.

Finally, there have been some comments about the SNF rates. One thing we have done is we think the impact of the SNF PPS will cause kind of a separation of those patients. Right now you have a system where there seems to be this concern about overpayment. When you look at the SNFs RUG rates for rehab and compare the highest per diem rate under the SNF RUG rates to what we have estimated to be the lowest Rand rate, the difference is at least $150. The lowest Rand rate, when made into a per diem, is at least $150 higher than the SNF Rug rate. So we think there will be quite a differentiation in these patients.

Also, we found that there's considerable concern about the method of payment for SNF PPS rehab patients, particularly in the hospital-based units. The hospital-based units will be making some serious decisions about the patients they treat given the rate of payment under the SNF PPS that may further differentiate those patients.

One last comment under the per discharges. Under the long term, I think the data that will be collected through MDS-PAC, if there is a common assessment tool, will help address, I think, a concern that Commissioner Newhouse has expressed over the years. And that is how to take post-acute care and move it into a larger per episode payment system.

We may not be able to get there now, because the data simply does not support defining that episode, which is different from per diem and can be different from per discharge. So for now, in looking at the deadlines and moving forward with the rehab PPS, those would be our recommendations.

Thank you.

MS. DEVINIA: My name is Lucille Devinia. I'm with the National Association for Home Care.

I wanted to comment specifically on the proposed recommendations on independent case managers and copays, but I think my comments go more broadly than that, too. I really very, very strongly want to urge the commission to understand and acknowledge and take into consideration the very, very dramatic changes that have happened in the Medicare home health benefit over the last 12 or so months.

Life in the Medicare home health benefit looks nothing like what it used to look like. What I hear kind of underlying a lot of the discussion around those recommendations were concerns about services that are billed for but not provided, services that are unnecessarily provided, or patients that are kept on service for unnecessarily long amounts of time.

What I really want to stress to you is that under the new interim payment system and the upcoming prospective payment system, those incentives don't exist anymore. Providers are under very, very heavy incentives to reduce lengths of stay, provide as few services per patient as possible, and to really streamline the provision of services in ways that we haven't seen before.

Also, unless I am mistaken, and I may be, but my understanding also is that physicians now are required under law to actually see with their own eyes Medicare home care patients every 60 days and to personally reassess their need for continued service, which gets at your discussion of the independent case managers, as well.

So all of that, I think, really comes together to give you a Medicare home care system and a benefit that just doesn't look like what it used to look like when MedPAC and ProPAC before it were considering these proposals.

If anything, life is much harder for providers in another sense, that patients who were eligible for the Medicare home health benefit on September 30th of 1997, the day before IPS began to go into effect, and patients who were eligible after that -- with the exception of a little venipuncture change that Congress made, the eligibility requirements have been completely unchanged. And yet the payment system has forced a very dramatic change in the type and scope and nature of services that are provided to people who meet the exact same eligibility requirements.

So providers have been placed in a very, very hard place in that context. And I think that might be an issue that really is worth MedPAC looking at and really understanding that.

But I really want to make the point that home care has changed a lot, and I really encourage you to acknowledge that and think about updating some of your recommendations to really reflect today's realities.

DR. WILENSKY: If there is data that you think we haven't seen that would support what you've said, we'd be glad to see it.

MS. DEVINIA: And we've been in conversation with Murray and Louisa and Scott and we'll continue to do that. Thank you.

MS. COYLE: My brain hurts. After two days here it always feels like cramming for exams.

Three quick comments in terms of rehabilitation PPS on behalf of many of our members. We have hospitals, rehab hospital units.

First, in support of one of the commission's recommendations, and that is to increase the sample size of the staff time measurements. I think Carolyn and Stephanie has also addressed the 2000 data points which means that there would have to be a whole lot of averaging that would have to go on before a whole lot of averaging goes on, whether it's per diem or per discharge, a real problem. Appreciate the draft recommendation.

Second, in support of the draft recommendation around a discharge based system, it is certainly, as we've spoken with our rehabilitation hospital and unit members, their preference in terms of a system for three very simple reasons. One, they believe it does provide incentives for efficiency. Two, it provides them with predictable payment over time. And three, they believe it is the only system that really facilitates case management.

I think, Ted, to your point about the changing structure of rehabilitation care, it is within a fixed payment kind of methodology, like a per discharge methodology, that allows them to change and move with those changes over time.

Third and last point around this whole issue of site of care substitution, back to Bill MacBain's SOCs, a lot of discussion yesterday -- you're going to be sorry you ever said that -- a whole lot of talk yesterday and today on this issue.

I think a lot of legitimate concern but we'd like to underscore the fact that there isn't much known. This is an area that's ripe for research, research, research. We don't know what the site of care substitution looks like around the area of rehabilitation facilities versus SNF facilities versus any other kind of sort of long-term care type of facility. I think it would be important to know what that research looks like before we try to fix something that we may not know is broken.

I think Stephanie and Carolyn both made the point, the new rehabilitation PPS system is designed to be layered on top of the SNF PPS system, and that is this issue of the highest level of care in the SNF PPS system reflects a minimum of 720 minutes a week. The lowest level of the rehab PPS is some 900 minutes per week.

The creation of these two separate systems may have the effect of separating this and kind of weeding it out, so it may or may not be a problem, but an area that would be helpful for the commission to take a look at as we move into time. Thanks.

DR. WILENSKY: Thank you. With that, we are in recess until January 14th.
[Whereupon, at 3:53 p.m., the meeting was adjourned.]